South Africa

Country Operational Plan

(COP) 2018

Strategic Direction Summary

March 22, 2018

Public Version

PEPFAR

U.S. President's Emergency Plan for AIDS Relief

Contents

List of Acronyms

Acronym	Definition
AGYW	Adolescent Girls and Young Women
AIDS	Acquired Immune Deficiency Syndrome
APR	Annual Program Results
ART	Antiretroviral Therapy
ARV	Antiretroviral (drug)
BAS	Basic Accounting System
CCMDD	Central Chronic Medicine Disease Dispensing and Distribution Programme
CDC	U.S. Centers for Disease Control and Prevention
CHW	Community Health Worker
CODB	Cost of Doing Business
COP	Country Operational Plan (PEPFAR)
COP18	2018 Country Operational Plan
DBE	Department of Basic Education
DoH	Department of Health
FBO	Faith-Based Organizations
FSW	Female Sex Workers
FTE	Full-Time Equivalent
FY	Fiscal Year
GBV	Gender-Based Violence
GFATM	Global Fund for AIDS, TB and Malaria
GoSA	Government of South Africa
HAST	HIV/AIDS, STIs, and TB (Directorate)
HIV	Human Immunodeficiency Virus
HSS	Health Systems Strengthening
HTS	HIV Testing Services
IM	Implementing Mechanism
LGBTI	Lesbian, Gay, Bisexual, Transgender and Intersex people
MSM	Men who have sex with men
NDoH	National Department of Health
NGO	Non-Governmental Organization
NHLS	National Health Laboratory System
NSP	South Africa National Strategic Plan for HIV, TB, and STIs, 2017-2022
OVC	Orphans and Vulnerable Children
PEPFAR	President's Emergency Plan for AIDS Relief
PFIP	Partnership Framework Implementation Plan
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
PrEP	HIV pre-exposure prophylaxis
PWID	People Who Inject Drugs
SA	South Africa
SANAC	South African National AIDS Council
SI	Strategic Information
SID	Sustainability Index Dashboard
SIMS	Site Improvement Monitoring Systems
SOP	Standard operating procedures
SRH	Sexual and Reproductive Health
StatsSA	Statistics South Africa

Acronym	Definition
STI	Sexually Transmitted Infections
TB	Tuberculosis
TLD	Tenofovir/Lamivudine/Dolutegravir fixed-dose combination (ARV)
TVET	Technical and Vocational Education and Training College
U.S.	United States
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations International Children's Emergency Fund
USAID	United States Agency for International Development
USD	U.S. Dollars
USG	United States Government
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization
ZAR	South African Rand

1.0 Goal Statement

In February 2018 President Ramaphosa announced a bold plan to provide life-saving antiretroviral therapy (ART) for 2 million additional people living with HIV (PLHIV) in South Africa (SA) by 2020. The government of SA (GoSA) has adopted global best practices and a focus-for-impact strategy in the National Strategic Plan for HIV, Tuberculosis (TB), and Sexually Transmitted Infections (STIs) (NSP) 2017-2022. Through the President's Emergency Plan for AIDS Relief (PEPFAR) Country Operational Plan 2018 (COP18), the United States (U.S.) government (USG) will support the GoSA to implement a strategic portfolio of multisectoral programs designed to accelerate epidemic control: (1) the HIV Treatment Surge to rapidly expand quality ART; (2) combination HIV prevention programs, including services for orphans and vulnerable children (OVC), programs to reduce HIV risk for adolescent girls and young women (AGYW) and saturation of voluntary medical male circumcision (VMMC) for men (15-34 years); and (3) transformative strategic information (SI) systems that link patients to care and drive broader program achievements. Active partner management and accountability, engagement at all spheres of government, and mobilizing civil society, the private sector and all stakeholders will be critical to achieving these goals.

PEPFAR SA has focused for impact both geographically and programmatically. During COP18, PEPFAR SA will continue to invest in South Africa's 27 highest HIV burden districts—accounting for 82% of PLHIV. Within these districts, COP18 will further focus on the four largest metropolitan districts (accounting for 31% of PLHIV) and populations with largest treatment gaps. PEPFAR SA continues to partner with key Ministries in SA's HIV response: Health, Social Development, Basic Education, National Treasury, Higher Education and Training, Justice and Constitutional Development, Correctional Services and Defence.

Programmatically, PEPFAR SA will more than double investments in supplemental health worker staff in the highest burden districts to fast-track the HIV Treatment Surge and will greatly expand community engagement through a comprehensive Community Health Worker (CHW) program. In COP18 PEPFAR SA will leverage the country's vibrant civil society, private sector, faith-based organizations (FBOs) and traditional structures to improve HIV service demand and access in highest burden communities and to improve adherence and retention. These investments will accelerate treatment scale-up through evidence-driven case finding, ART linkage, adherence and retention. Prevention shifts will include self-screening strategies and index testing, and expansion of pre-exposure prophylaxis (PrEP) services.[1] PEPFAR SA will also prioritize investments in health systems that contribute directly to epidemic control, including provincial data centers, training and management programs for CHWs, and increased service space at facilities.

PEPFAR SA has improved the way we do business, strengthening management and accountability, and implementing a robust program to kick-start the Treatment Surge during the

[1] All interventions are aligned with the 2017-2022 South Africa NSP, the UNAIDS 90-90-90 goals, WHO guidelines and global best practices, and with the PEPFAR Strategy for Accelerating HIV/AIDS Epidemic Control (2017-2020).

current implementation year. Beginning in 2017, PEPFAR SA intensified partner performance management, increasing oversight at the site, partner and PEPFAR staff levels, introducing standardized performance guidance and measurement tools, and tightening joint management and oversight with the GoSA. PEPFAR SA also aligned its programming geographically across agencies to improve management efficiencies. PEPFAR SA has intensified province-level support to accelerate program and policy implementation.

2.0 Epidemic, Response, and Program Context

2.1 Summary statistics, disease burden and country profile

SA is an upper-middle income country, with many cultures, languages, races, and religions shaping its health profile. The population is estimated at 56.5 million, of which approximately 51% (28.9 million) are female. Life expectancy at birth is estimated to be 64.0 years (66.7 years for females; 61.2 years for males) and the infant mortality rate is 32.8 per 1,000 live births.[2]

In 2017, SA's HIV disease burden was an estimated 7,203,313 PLHIV,[3] of which more than half (53%) were women aged 25 and older. The estimated number of new infections among adults declined by 53% from 1999 to 2017, but incidence remains high, with an estimated 266,988 new infections in 2017.[4] Among children, the estimated number of mother-to-child transmissions declined by 80% from 2004 to 2017, and 70% of those transmissions are now estimated to occur during breastfeeding. This decline in incidence and shift of transmission from perinatal to postnatal has led to a shift in the age distribution of HIV-infected children, almost half (45%) of whom are now 10-14 years of age.[5]

South Africa's HIV epidemic is largely driven by heterosexual transmission, with underlying behavioral, socio-cultural, economic, and structural factors influencing HIV transmission risk. These factors include national and regional population mobility and migration; economic and educational status; lack of knowledge of HIV status; alcohol and drug use; early sexual debut; sexual and gender-based violence (GBV); low prevalence of male circumcision; intergenerational sex; multiple and concurrent sexual partners; inconsistent condom use, especially in longer-term relationships and during pregnancy/post-partum; discrimination and stigmatization; and gender dynamics, including unequal power relations between men and women.

The SA National Department of Health (NDoH) and the Departments of Health (DoH) at provincial and district levels lead the public-sector HIV treatment and biomedical prevention efforts to achieve epidemic control. As of December 2017, there are 4.0 million people on ART in

[2] Statistics South Africa [StatsSA], Mid-year population estimates, 2017. Statistical Release P0302, StatsSA: Pretoria.
[3] Comprising: 310,593 children <15 years; 5,871,927 adults 15-49 years; and, 1,020,792 adults 50+ years. Source: Johnson LF, et al. (2017) Progress towards the 2020 targets for HIV diagnosis and ART in SA. S Afr J HIV Med. 2017;18(1), a694.
[4] Ibid.
[5] Ibid.

the public sector, including 161,823 children (<15 years) and 3,838,739 adults).[6] In addition, there are an estimated 200,000 PLHIV on ART in the private sector. SA manages the largest national treatment program in the world, although with universal ART eligibility, overall treatment coverage is only 55.7%.[7] ART coverage is higher among adult females (15+, 58.3%) than among adult males (15+, 51.0%) but is extremely low among adolescent girls and young women (15-24, 38%). ART coverage among children is estimated to be 56.0% (Table 2.1.2). The national VMMC coverage is an estimated 66% of males aged 15-34 years.[8] Results from the new HIV population-based survey, currently being completed by the SA Human Sciences Research Council with PEPFAR SA support, are expected to be released in April/May 2018.

SA has made significant progress in the policy environment since 2016, with the adoption of Universal Test and Treat, same-day initiation, differentiated service delivery, including the expansion of centralized chronic medicines dispensing and distribution (CCMDD) models as vehicles toward universal access to ART and multi-month antiretroviral drug (ARV) supply, PrEP targeted at key population groups, and the AGYW-focused national "She Conquers" campaign.

In 2017, the NDoH together with PEPFAR SA developed an HIV Treatment Surge plan to accelerate epidemic control in SA by putting a total of 6.1 million individuals on ART in the public health system by December 2020. The Treatment Surge will support interventions and direct service delivery in the 27 priority districts that account for 82% of the HIV burden in SA, and high-impact technical assistance and above-site interventions that support the national ART program. Specifically, the Treatment Surge will support six targeted investments to expand effective and quality service delivery:

1. Facility-based Health Workers: Placement of 20,000 supplemental health workers from nine cadres to provide targeted facility-based direct service delivery in existing high-volume public health facilities, to identify PLHIV, initiate and retain them on ART. These cadres will be placed based on facility-specific needs, but are expected to include over 12,000 clinical and clinical support staff, complemented by management and lay staff.
2. Community Health Workers: Optimization of the national Ward Based Primary Health Care Outreach Team program to ensure a bridge between public health facilities and the communities in their catchment area, including demand creation and service delivery to achieve GoSA targets. This initiative plans to support >8,000 CHWs and Outreach Team Leads, in addition to the existing 51,000 DoH-funded CHWs. PEPFAR SA investments will also support NDoH to establish strong training, performance expectations, management structures, standard remuneration, and monitoring systems to ensure impact from community workers.
3. ARV drugs and community ARV delivery: Funding for ARVs to ensure uninterrupted drug supply for new and continuing ART patients, including community-based ARV distribution implemented as part of differentiated service delivery.

[6] NDoH Program data (DHIS), December 2017.
[7] Johnson, *op. cit*.
[8] Based on the online VMMC Decision-Makers' Program Planning Toolkit (DMPPT) 2, a PEPFAR-funded monitoring and planning tool that generates VMMC coverage estimates, targets and impact projections at the district level, dis-aggregated by five-year age group. http://avenirhealth.org/policytools/DMPPT2/index.html#

4. Activation of FBOs and traditional structures: Leveraging these crucial structures to influence social norms, mobilize demand for services, actively link PLHIV to ART, and support ART adherence.
5. Mobilization of the private sector: Working through General Practitioners and the private sector, reach and provide services to people who do not access public health facilities, particularly hard-to-reach men. Through a grand challenge, generate innovative solutions from non-traditional stakeholders.
6. Health information acceleration: Targeted support to the health information systems needed to strengthen data and information use, including through provincial data centers.

Major programmatic and system gaps or barriers to achieving epidemic control remain. Patients continue to start treatment too late and too sick; in 2016/2017, 24% of patients initiating ART in Gauteng Province had a CD4 count under 200.[9] Linkage and retention must be improved, with only approximately 75% of patients with known HIV infection on ART.[10] The nexus with the TB epidemic continues to drive high morbidity and mortality, with the legacy of apartheid and significant income inequality posing additional challenges to the TB and HIV response.

Gross National Income per capita is estimated at U.S. Dollar (USD) 5,480 in 2016.[11] Total health expenditure is estimated to be about 9% of the Gross Domestic Product with health spending expected to reach SA Rand (ZAR) 205 billion (approximately USD17.1 billion[12]) in 2018/19.[13] A large proportion of this spending occurs in the private health sector, which caters for an estimated 16% of the total population. GoSA is committed to continuously increase budgetary support for the HIV response. In the 2018 budget, an additional ZAR1 billion (approximately USD83 million[14]) was added to the HIV/TB Conditional Grant to support ART expansion in 2021, and ZAR4.4 billion was reprioritized within the grant over 3 years to support expansion of the CHW portfolio.[15] Other HIV-related investments in the 2018 budget include expansion of the CCMDD program to enable 3 million chronic patients to pick up medicines outside the clinic, and implementation of programs to support proposed National Health Insurance, which includes contracting with General Practitioners for services.

HIV prevalence and incidence vary significantly across geographic areas; over half (54%) of PLHIV are concentrated in the Gauteng and KwaZulu-Natal provinces.[16] Tables 2.1.1 and 2.1.2 below summarize the key HIV epidemiological data and provide a national view of the 90-90-90 cascade.

[9] NHLS, FY2016/17, cited in Pillay Y. South Africa's HIV Program and Partnership with PEPFAR. Presentation to the PEPFAR Regional Planning Meeting, 2/25/2018.
[10] PEPFAR Annual Program Results FY2017.
[11] Gross National Income per capita, Atlas method (current USD). World Bank: World Development Indicators. Online: http://data.worldbank.org/indicator/
[12] Using the current Exchange Rate (March 2018) of ZAR12.0:USD1.
[13] Gross National Income per capita, Atlas method (current USD). World Bank: World Development Indicators. Online: http://data.worldbank.org/indicator/
[14] Using the current Exchange Rate (March 2018) of ZAR12.0:USD1.
[15] National Treasury, 2018 Budget Speech. Online: http://www.treasury.gov.za
[16] Johnson, *op. cit*.

Table 2.1.1 Government of South Africa Results

Table 2.1.1 Government of South Africa Results															
	Total		**<15**				**15-24**				**25+**				***Source, Year*** *(Full references are below table)*
			Female		**Male**		**Female**		**Male**		**Female**		**Male**		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	56,521,900	100 %	8,342,334	14.8 %	8,382,497	14.8 %	4,831,221	8.5 %	4,792,051	8.5 %	15,727,750	27.8%	14,446,094	25.6%	*Statistics South Africa (StatsSA), Mid-year population estimates, 2017*
HIV Prevalence (%)		12.7 %		1.9%		1.9%		11.6 %		3.7%		23.6%		16.1%	*Johnson LF, et al. (2017). Mid-year 2017.*
AIDS Deaths (per year)	123,200		AIDS deaths in male & female children <15= 10,675				N/A		N/A		AIDS deaths in female adults ≥15= 56,350		AIDS deaths in male adults ≥15= 56,1		*Ibid.*
# PLHIV	7,203,313		154,874		155,719		554,338		177,317		3,827,093		2,333,972		*Ibid.*
Incidence Rate (Yr)		0.54 %		0.1 %		0.1 %		2.04 %		0.66 %		0.56%		0.56%	*Ibid.*
New Infections (Yr)	266,988 (2017)		8,552		7,005		97,827		31,928		91,248		81,993		*Ibid.*
Annual births	1,198,481	100 %													*StatsSA, Mid-year population estimates, 2017*
% of Pregnant Women with at least one antenatal care visit	N/A	94%	N/A	N/A			N/A	N/A			N/A	N/A			*United Nations International Children's Emergency Fund (UNICEF), 2018*
Pregnant women needing ARVs	267,207	100 %													*Johnson LF, et al. (2017). Mid-year 2017.*
Orphans (maternal, paternal, double)	1,560,000 Maternal; 2,530,000 Paternal; 820,000 Double		N/A		N/A		N/A		N/A		N/A		N/A		*UNAIDS South Africa Spectrum, 2016*

Table 2.1.1 Government of South Africa Results															
	Total		**<15**				**15-24**				**25+**				***Source, Year*** *(Full references are below table)*
			Female		**Male**		**Female**		**Male**		**Female**		**Male**		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Notified TB cases (Yr)	244,053		N/A		N/A		N/A		N/A		N/A		N/A		*World Health Organization, 2016*
% of TB cases that are HIV infected	135,169	59%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	*Ibid.*
% of Males Circumcised		66%			N/A	N/A			N/A	N/A			N/A	N/A	*VMMC Decision-Makers' Program Planning Toolkit (DMPPT) 2*
Estimated Population Size of MSM[a]	299,000	N/A													*University of California, San Francisco, 2018*
MSM[a] HIV Prevalence	N/A	28% (range of 22% -48)													*University of California, San Francisco, 2015*
Estimated Population Size of FSW[a]	112,000	N/A													*University of California, San Francisco, 2018*
FSW[a] HIV Prevalence	62,720	56%					N/A	N/A			N/A	N/A			*SANAC, 2015*
Estimated Population Size of PWID[a]	75,700														*Ibid.*
PWID[a] HIV Prevalence	10,598[b]	14.0 %													*Scheibe, et al, 2014*
Estimated Size of Priority Populations: Military	76,480	100 %													*South African Department of Defence, 2017*

Table 2.1.1 Government of South Africa Results															
	Total		<15				15-24				25+				***Source, Year*** *(Full references are below table)*
			Female		Male		Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Estimated Size of Priority Populations: Black African Females 15-34 years	8,616,604	100 %													*StatsSA, Mid-year population estimates, 2017*
Estimated Size of Priority Populations: Black African Males 25-49 years	8,635,979	100 %													*StatsSA, Mid-year population estimates, 2017*

[a] *MSM: Men who have sex with men; FSW: Female sex worker; PWID: People who inject drugs*

[b] *Number calculated using prevalence rate of Scheibe et al applied to SANAC estimated population size of PWID.*

Table 2.1.1 References-

- Johnson LF, et al. (2017) Progress towards the 2020 targets for HIV diagnosis and ART in SA. S Afr J HIV Med. 2017;18(1), a694.
- *SANAC Programmatic Mapping and Size Estimation Study of Key Populations in South Africa, 2015 Final Report, October 2015*
- *Scheibe, A, Brown, B, dos Santos, M, Final Report: Rapid assessment of HIV prevalence and HIV-related risks among people who inject drugs in five South African cities, February 2015.*
- *Shisana, O, Rehle, T, Simbayi, LC, Zuma, K, Jooste, S, Zungu, N, Labadarios, D, Onoya, D et al. (2014). South African National HIV Prevalence, Incidence and Behaviour Survey, 2012. Cape Town, HSRC Press*
- *South African Department of Defence Annual Report 2016/17. Accessed March 19 2018 at http://dod.mil.za/documents/annualreports/DoD%20Annual%20Report%202017%20web.pdf*
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- *UNAIDS Spectrum Estimates for South Africa 2015. Version 5.4 EPP/Spectrum. Online: http://www.unaids.org/en/dataanalysis/datatools/spectrumepp; Accessed 01 Mar, 2017*
- *UNICEF Antenatal Care Coverage Data, updated February 2018. Accessed March 19 2018 at https://data.unicef.org/topic/maternal-health/antenatal-care/.*
- *World Bank: World Development Indicators. Online: http://data.worldbank.org/indicator/*
- *World Health Organization (2017). Global Tuberculosis Report, 2016*

Table 2.1.2 90-90-90 cascade: HIV diagnosis, treatment and viral suppression

Table 2.1.2 90-90-90 cascade: HIV diagnosis, treatment and viral suppression										
Epidemiologic Data					**HIV Treatment and Viral Suppression**			**HIV Testing and Linkage to ART Within the Last Year[f]**		
	Total Population Size Estimate (#)[a]	**HIV Prevalence (%)[b]**	**Estimated Total PLHIV (#)[b]**	**PLHIV diagnosed (#)**	**On ART (#)[b]**	**ART Coverage (%)**	**Viral Suppression (%)[c]**	**Tested for HIV (#)**	**Diagnosed HIV Positive (#)**	**Initiated on ART (#)**
Total population	56,521,900	12.7%	7,203,313		4,009,162	~55.7%	~83%	13,925,665	1,117,343	*1,007,317*
Population <15 years	16,724,830	1.9%	310,593		173,833	~56.0%	~65%	1,200,648	33,885	*20,433*
Men 15+ years	19,238,145	13.0%	2,511,289		1,281,766	~51.0%	~80%	5,455,403	410,383	*357,826*
Men 15-24 years	4,792,051	3.7%	177,317		unknown	~56%[e]	~64%	unknown	unknown	unknown
Men 25+ years	14,446,094	16.1%	2,333,972		unknown	~53%[e]	~81%	unknown	unknown	unknown
Women 15+ years	20,558,971	20.9%	4,381,431		2,553,563	~58.3%	~85%	7,393,376	656,392	*629,058*
Women 15-24 years	4,831,221	11.6%	554,338		unknown	~38%[e]	~77%	unknown	unknown	unknown
Women 25+ years	15,727,750	23.6%	3,827,093		unknown	~73%[e]	~86%	unknown	unknown	unknown
MSM[d]	299,000	28%	83,720	37,916	26,006	31.1%	26.5%	7,366	783	*609*
FSW[d]	112,000	56%	62,720	44,555	14,276	22.8%	18.1%	20,902	2,785	*616*
PWID[d]	75,700	14%	10,598	NA	NA	NA	NA	772	170	*7*
Priority Pop (Inmates)								60,641	4,799	*3,795*

[a] Statistics South Africa [StatsSA], Mid-year population estimates, 2017. Statistical Release P0302, Statistics South Africa: Pretoria

[b] Johnson LF, et al. (2017) Progress towards the 2020 targets for HIV diagnosis and ART in SA. S Afr J HIV Med. 2017;18(1), a694. (mid-year 2017; ART numbers include estimated private sector contribution)

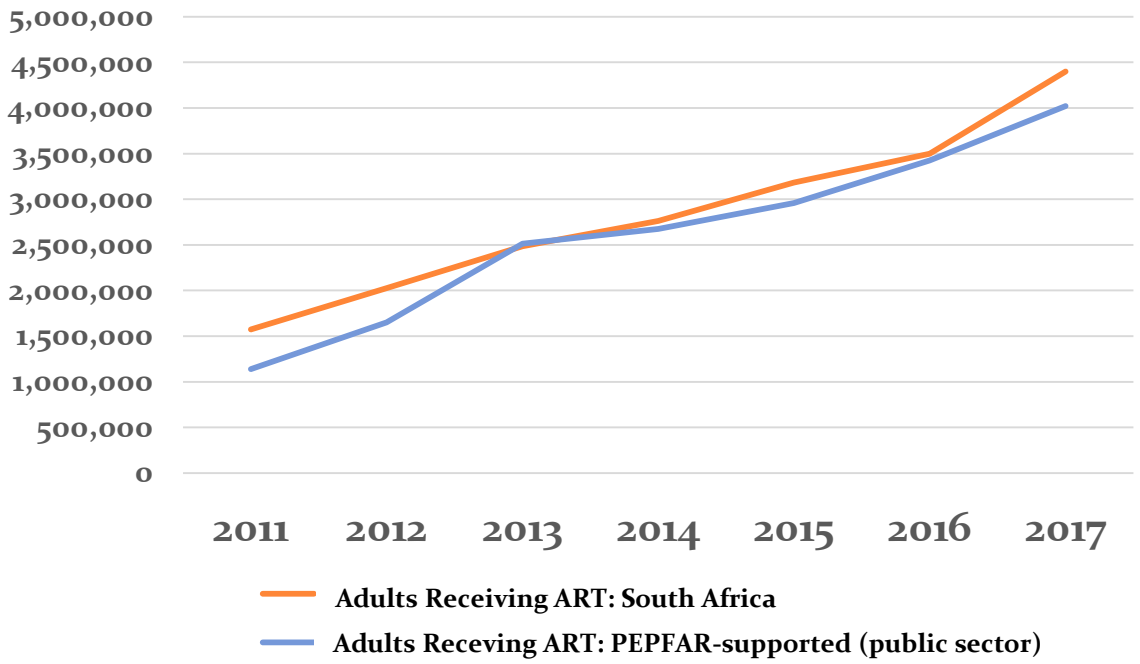
[c] National Health Laboratory Services (NHLS) Program dashboard (2017 data), Feb 2018.

[d] MSM: Men who have sex with men; FSW: Female Sex Worker; PWID: People who inject drugs; for data references see Table 2.1.1

[e] Estimated based on PEPFAR reported data (Quarter 1, FY2018)

[f] PEPFAR reported data (APR 2017)

Figure 2.1.3 Individuals currently on Treatment in South Africa



Notes:

- 'South Africa' values (orange line) are derived from the Thembisa model inputs, which estimate the number of individuals receiving ART in the public and private sector using program reporting inputs and estimated service provision via the private sector.
- 'PEPFAR-supported' values (blue line) represent PEPFAR results from all 52 districts from the public sector. PEPFAR SA provides intensive support to 27 highest burden districts. PEPFAR SA provides systems support to the remaining 25 lower-burden districts through investments at the central level (see Section 6).

2.2 Investment Profile

SA's national HIV response is funded primarily through public revenue, with additional funding from external development partners (donors) and the private sector.

In 2016/17, the SA HIV response was funded primarily through the GoSA at ZAR19.6 billion (USD1.34 billion[17]) (Table 2.2.1). PEPFAR was the second largest source of funds and contributed ZAR6.62 billion (USD490.17 million[18]). The Global Fund for AIDS, TB and Malaria (GFATM) was the next-largest funding source at ZAR776.9 million (USD54.29 million). The 2013 National AIDS Spending Assessment reported other external sources (bilaterals, multilaterals, and foundations) accounting for about 3% of HIV response funding. Private companies and insurance contributed around 8%. According to the NSP 2017-2020, insurance costs for private ART patients are estimated to be ZAR1.6billion in 2017/18.

[17] Using the average Exchange Rate April 2016-March 2017 of ZAR14.58:USD1.
[18] Using the PEPFAR FY2017 Expenditure Analysis Exchange Rate of ZAR13.5:USD1.

Within the GoSA response, the NDoH is the largest spender on HIV services, primarily via the HIV/TB Conditional Grant mechanism (ZAR20.5 billion in 2018/19), followed by the Department of Social Development (ZAR1.8 billion for 2018/19). An additional ZAR1.9 billion is being allocated in 2017/18 and 2018/19 to support implementation of the HIV and TB Investment Case and the new NSP including the continued expansion of ART to PLHIV. PEPFAR's anticipated fiscal year (FY)[19] 2019 HIV funding in SA is ZAR8.15 billion (USD678.8 million).[20]

Due to SA's high HIV burden and the already large and growing number of patients on treatment, HIV costs are expected to increase over the next decade, primarily driven by costs of ARVs and ART service delivery. Introduction of Tenofovir/Lamivudine/Dolutegravir fixed-dose combination (TLD) is expected to partially offset these increases. Modeling undertaken as part of the SA HIV and TB Investment Case found that maximizing prevention efforts (specifically condom provision and VMMC) was more cost-effective than ART provision, and that an approach that combines treatment and prevention is necessary to achieve the 90-90-90 targets. This strategy requires a steadily increasing investment in HIV programs to reach 90-90-90. Given SA's constrained economy, the GoSA has leveled funding for many services, and future rising HIV and TB treatment costs are projected to consume an increasing share of the health budget.

[19] The GoSA fiscal year is April-March, and is referenced as two calendar years (e.g. FY2016/17 for the period April 2016-March 2017). The USG fiscal year is October to September, and is referenced in relation to the latter calendar year (e.g. FY2017 for the period October 2016-September 2017).
[20] Using the current Exchange Rate (March 2018) of ZAR12.0:USD1.

Table 2.2.1 Annual Investment Profile by Program Area

Table 2.2.1 Annual Investment Profile by Program Area				
Program Area	**Total Expenditure (USD)**	**% GoSA (FY 2016/17)**	**% PEPFAR (FY 2017)**	**% GFATM (FY 2016/17)**
Clinical care, treatment and support	978,045,721	84%	14%	2%
Community-based care, treatment and support	198,808,165	81%	17%	2%
Prevention of Mother-to-Child Transmission [a]	41,950,347	45%	55%	0%
HIV Testing Services	126,663,865	45%	55%	0%
VMMC	96,244,313	22%	78%	0%
Priority population prevention	82,030,609	48%	45%	7%
Key population prevention [b]	31,860,980	52%	23%	25%
OVC [c]	124,588,488	63%	37%	0%
Laboratory [d]	16,083,574	0%	100%	0%
SI, surveys and surveillance [d]	36,268,046	0%	89%	11%
Health Systems Strengthening (HSS) [d]	11,638,397	0%	81%	19%
Other HIV spending (not in COP table) [d]	143,889,770	93%	0%	7%
Total (USD)	**1,888,072,275**	**71%**	**26%**	**3%**

General Notes:

- GoSA figures are based on Basic Accounting System (BAS) actual expenditures for FY2016/17 (exchange rate: ZAR14.58:USD1). GFATM figures are actual expenditures from Fy2016/17 (exchange rate: ZAR14.58:USD1). PEPFAR figures are based on FY2017 expenditures (exchange rate: ZAR13.5:USD1).
- The table provides a broad profile of expenditures and budgets for HIV spending in SA, and is not comprehensive of all HIV expenditures in SA. BAS data do not provide specific information on spending and budget allocation for several of the program areas or component areas listed, including laboratory, OVC, Communications, Monitoring and Evaluation, Other Prevention, Policy and Systems Development. This lack of information does not reflect a lack of GoSA expenditure in these program areas.

[a] The 45% attributed to GoSA is an underestimate as it does not include ARVs, HTS or full estimates of staff time.

[b] The GoSA investment in key population prevention includes costs for interventions in high-transmission areas.

[c] The GoSA does not track OVC investments in the BAS. OVC investments in this table include HIV/AIDS investments by the Department of Social Development, and the life skills education grant from the Department of Basic Education. This lack of information does not reflect a lack of GoSA expenditure on OVC activities.

[d] GoSA Laboratory, HSS and SI expenditures are not coded in the BAS. All GoSA Laboratory, HSS and SI expenditures that do not relate to the PEPFAR Investment Profile program areas are included in "Other HIV Spending". PEPFAR Laboratory expenditures are related to systems strengthening. The majority of PEPFAR's SI and HSS expenditures are integrated across other program areas; the expenditures reflected here include only those that are not assigned to another program area.

Table 2.2.2 Annual Procurement Profile for Key Commodities

Table 2.2.2 Annual Procurement Profile for Key Commodities				
Commodity Category	**Total Expenditure (USD)**	**% GoSA (FY 2016/17) [a]**	**% PEPFAR (FY 2017)**	**% GFATM (FY 2016/17) [a]**
ARVs	420,375,997	97%	0%	3%
Rapid test kits	7,974,140	98%	2%	0%
Other drugs	0	0%	0%	0%
Lab reagents	188,174,096	100%	0%	0%
Condoms	35,088,175	100%	0%	0%
Viral Load commodities	0	0%	0%	0%
VMMC Kits	16,342,333	39%	61%	0%
Other commodities [b]	14,738,848	0%	100%	0%
Total	**682,693,589**	**95%**	**4%**	**2%**

[a] Exchange rate: ZAR14.58:USD1

[b] PEPFAR Other Commodities is derived from the FY2017 Expenditure Analysis DataNab Tool as the remaining portion of "Other Supplies" after subtracting VMMC and Lab commodities.

Table 2.2.3 Annual USG Non-PEPFAR Funded Investments and Integration

Table 2.2.3 Annual USG Non-PEPFAR Funded Investments and Integration					
(USG) Funding Source	**Total USG Non-PEPFAR Resources (USD)**	**Non-PEPFAR Resources Co-Funding PEPFAR IMs[b] USD)**	**# Co-Funded IMs[b] (USD)**	**PEPFAR COP Co-Funding Contribution (USD)**	**Objectives**
USAID Maternal and Child Health	N/A	N/A	N/A	N/A	N/A
USAID TB	13,000,000	N/A	N/A	N/A	TB technical assistance to GoSA
USAID Malaria	N/A	N/A	N/A	N/A	N/A
Family Planning	N/A	N/A	N/A	N/A	N/A
National Institutes of Health	77,000,000[a]	N/A	N/A	N/A	To advance health objectives
Centers for Disease Control and Prevention (CDC) - Global Health Security	N/A	N/A	N/A	N/A	N/A
Peace Corps	2,300,000	N/A	N/A	N/A	N/A
Department of Defense Ebola	N/A	N/A	N/A	N/A	N/A
Millennium Challenge Corporation	N/A	N/A	N/A	N/A	N/A
Total	**15,300,000**	**0**	**0**	**0**	

[a] Of which 60-70% are HIV/TB-focused.
[b] IM: Implementing Mechanism

Table 2.2.4 Annual PEPFAR Non-COP Resources

Table 2.2.4 Annual PEPFAR Non-COP Resources						
Funding Source	**Total PEPFAR Non-COP Resources (USD)**	**Total Non-PEPFAR Resources (USD)**	**Total Non-COP Co-funding PEPFAR IMs[a]**	**# Co-Funded IMs[a]**	**PEPFAR COP Co-Funding Contribution (USD)**	**Objectives**
DREAMS Innovation Challenge Fund	3,000,000[b]	N/A	N/A	N/A	33,323,382	N/A
VMMC – Central Funds	17,918,315	N/A	1	18547	22,853,589	Reach VMMC targets
Other PEPFAR Central Initiatives	83,917,320	N/A	10	16772,14295,18482,17537,70310,70287,70288,70289,70290,70301	110,788,254	HIV Treatment Surge
Other Public-Private Partnership	1,500,000	N/A	2	18484, 18482	N/A	VMMC demand creation via airtime voucher messaging; HCT in private-sector pharmacies; improving management and leadership for the HIV response.
Total	**103,335,635**	**0**	**N/A**	**N/A**	**166,965,225**	

[a] IM: Implementing Mechanism
[b] FY2017 and FY2018 only

2.3 National Sustainability Profile Update

The second round of PEPFAR SA's National Sustainability Profile was completed in November 2017 using the Sustainability Index and Dashboard (SID) 3.0. The process was led by the South African National AIDS Council (SANAC), GoSA, UNAIDS and the PEPFAR SA team, and included 45 multisectoral partners from government and non-governmental organizations (NGOs), the private sector, civil society, health bilateral and multilateral partners, and international NGOs working in South Africa's HIV program. The group completed the review of the index's 15 critical sustainability elements. The SID 2017 summary was approved through the bilateral Partnership Framework Implementation Plan (PFIP) Management Committee, and the results have been presented in various stakeholders' meetings including through the PFIP, Health Partners Forum, SANAC Civil Society Forum, and UN Joint Team.

The SA SID 3.0 demonstrated a high level of sustainability (score of 8.5/10) in eight of the 15 critical elements,[21] and a score of 8 or higher in an additional three elements.[22] Four elements were identified with vulnerabilities to sustainability: service delivery; human resources for health; commodity security and supply chain; and epidemiological and health data.

In COP18, PEPFAR SA will continue to invest in those program elements with the weakest sustainability scores. PEPFAR SA also continues to work closely through the bilateral workstreams to ensure that the COP18 investments both leverage and complement the investments of the GoSA and other donors. In particular, PEPFAR SA continues to work closely with the GFATM CCM and Fund Portfolio Manager to strengthen the alignment of COP18 with the activities to be included in the next GFATM Request for Funding. The ongoing USG participation on the CCM and Oversight Committee has resulted in increased efficiencies and proactive reprogramming to support additional effective interventions.

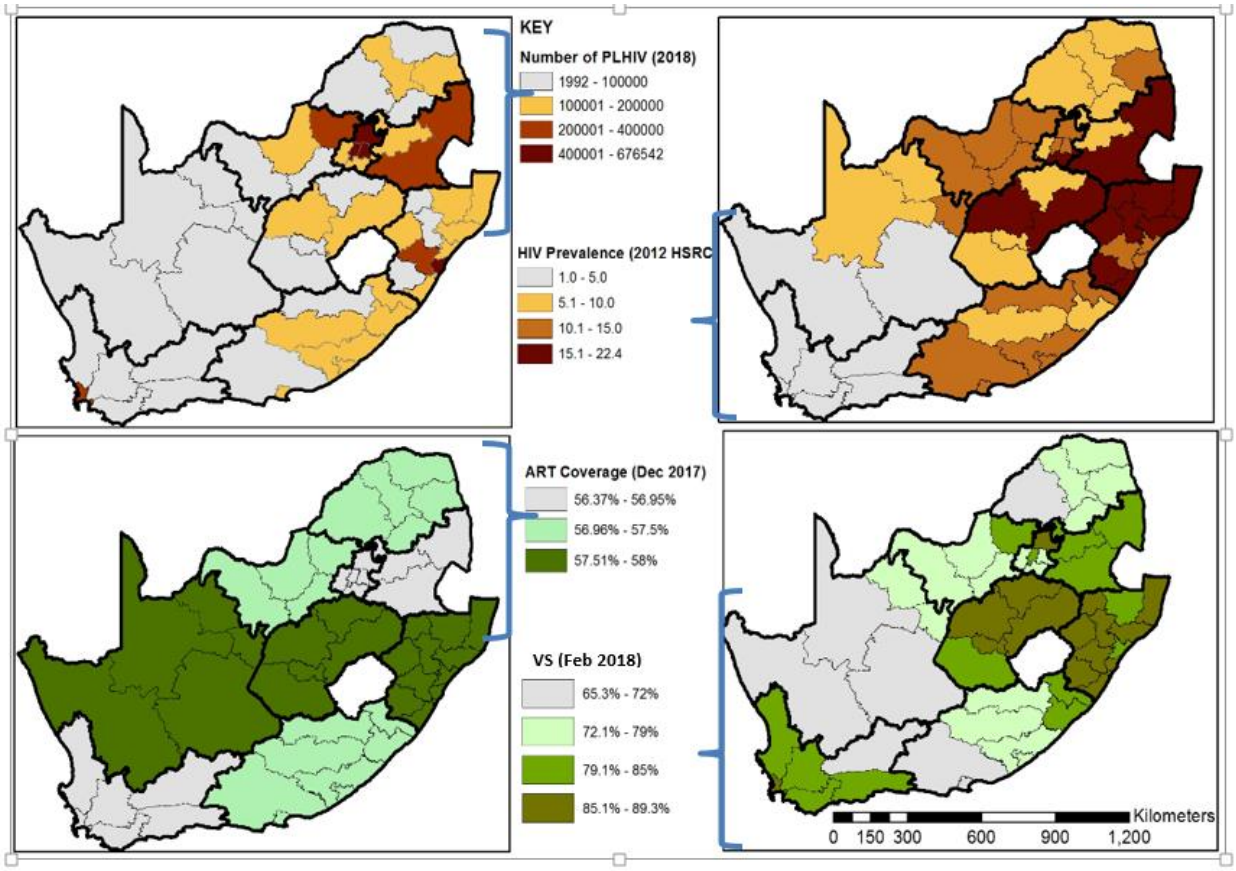
2.4 Alignment of PEPFAR investments geographically to disease burden

In COP18 PEPFAR SA continues to prioritize the 27 districts that account for 82% of the national HIV burden, which are the same 27 focus-for-impact districts in the NSP. To further focus the PEPFAR SA investment, COP18 resources are concentrated in the four largest metropolitan districts (Johannesburg, eThekwini, Ekurhuleni, Tshwane), which account for 31% of the national HIV burden. The alignment analysis revealed the need to make additional investments in the 1,437 highest burden facilities that serve 90% of the PLHIV on treatment in the 27 priority districts. In COP18, PEPFAR SA has increased the investment in all of these facilities to support additional human resources to supplement existing DoH staff. PEPFAR SA, DoH, and implementing partners are monitoring these facilities on a weekly basis to optimize allocation of supplemental staff, technical assistance and other resources (i.e., information technology, infrastructure, and equipment).

[21] (1) Planning and coordination; (2) policies and governance; (3) private sector engagement; (4) civil society engagement; (5) laboratory; (6) domestic resource mobilization; (7) technical and allocative efficiencies; and (8) performance data.

[22] (1) Public access to information; (2) quality management; and (3) financial/expenditure data.

Figure 2.4.1 PLHIV, HIV Prevalence, ART coverage, and Viral Suppression, by District



2.5 Stakeholder Engagement

The process of developing COP18 has been open and consultative, and the proposed plan reflects the strong engagement with and input from a range of stakeholders. In particular, PEPFAR SA received substantial input from the GoSA, the GFATM and other donors, Civil Society and the private sector to prioritize investments included in COP18.

The GoSA continues to provide leadership in planning and implementing the PEPFAR program in South Africa. The bilateral partnership is led by the PFIP Steering Committee, co-chaired by the Minister of Health and the U.S. Ambassador to SA, along with the deputy ministers from important GoSA departments. The Steering Committee provides guidance to the PFIP Management Committee, co-chaired by a senior manager from the Ministry in the Presidency for Planning, Monitoring and Evaluation and the interagency PEPFAR Coordinator, and with representation of senior officials from all key GoSA departments. The Management Committee in turn guides the joint technical workstreams, which oversee the implementation of the PEPFAR SA program throughout the year. At each of these levels, the COP18 plan was discussed and reviewed, and members provided strategic input. In addition to these formal, routine bilateral consultations, from December 2017 through February 2018 PEPFAR SA joined with SANAC to

convene COP18 consultations with Provincial AIDS Councils and Provincial HIV/AIDS, STI and TB (HAST) Managers from the eight provinces in which PEPFAR SA supports the 27 focus districts.

As part of the COP18 development process, PEPFAR SA organized targeted consultations and leveraged routine coordination meetings to engage with multilateral and bilateral donors and key international NGOs and foundations. These included meetings of the SANAC NSP Steering Committee; SA Health Partners Forum; GFATM Country Coordination Mechanism, Request for Funding Committee and Fund Portfolio Management Team; Bill and Melinda Gates Foundation; Clinton Health Access Initiative; and the UN Joint Team. PEPFAR SA staff also regularly discuss COP implementation and proposals in the SA HIV Think Tank, the SA TB Think Tank, and other national committees and working groups.

Civil Society has been actively engaged throughout the COP18 planning process, including consolidating strategic insights into "The People's COP", presented at the COP18 Regional Planning Meeting in Johannesburg in February 2018. Valuable national consultations were held with the SANAC Civil Society Forum and with national PLHIV organizations. At each consultation PEPFAR SA presented on the COP18 planning process, on program results and COP18 priorities, and civil society representatives provided input on key program areas through thematic sub-groups and in plenaries.

Private Sector stakeholders also provided valuable insights in the COP18 planning process and during the current implementation year through participation in the SID workshop, and through consultations with important private sector partners. These partners included Discovery Health, Vodacom, Johnson and Johnson, MassMart, and SA Breweries, among others.

Finally, there was robust participation of external partners in strategic discussions at the COP18 Regional Planning Meeting. Six representatives from South African civil society were joined by government and SANAC representation, as well as other representatives from advocacy, international NGOs and multilateral organizations. Inputs from these stakeholders resulted in a stronger investment plan for COP18.

Building on this annual planning process, PEPFAR SA will continue to engage with external partners, including civil society at national, provincial, and district levels, to support optimized implementation of COP18. COP18 implementation will include ongoing consultations, including sharing of quarterly results at the national and provincial levels. COP18 implementation will also leverage current efforts to deepen engagement with FBOs and with national and provincial authorities through the Treatment Surge.

3.0 Geographic and Population Prioritization

During the COP18 planning process, PEPFAR SA utilized new population, burden and coverage estimates to prioritize districts and populations across the portfolio. New district-level PLHIV and coverage estimates revealed substantial treatment gaps especially in the four largest metropolitan

districts (Johannesburg, eThekwini, Ekurhuleni and Tshwane). As a result, PEPFAR SA is redoubling efforts in these four districts to reach saturation (81% treatment coverage) by September 2019 and accelerate treatment coverage in the remaining twenty-three priority districts to reach saturation by December 2020.

In most geographic areas, there are substantial treatment gaps across age and sex bands (men 25+ years, women 25+ years, AGYW 15-24 years, and children <15 years). These populations are prioritized with customized program solutions for accelerated ART coverage. To expand coverage among men, PEPFAR SA will leverage lessons learned and strengthen linkages with the successful VMMC program, which has reached saturation among 15-34 year-olds in eight districts (including Johannesburg, Ekurhuleni, and Tshwane), anticipates reaching saturation in an additional three districts by September 2019, and in all remaining districts by 2020. Among women, PEPFAR SA will expand treatment coverage by leveraging lessons learned and strengthening linkages with the successful Prevention of Mother to Child Transmission (PMTCT) program, which has reached saturation levels across all districts and reduced transmission to below 2%. To expand treatment coverage among AGYW, PEPFAR SA will leverage lessons learned and strengthen linkages with the She Conquers platform. To close the treatment gap among children, PEPFAR SA will leverage lessons learned and strengthen linkages with the OVC program.

Among priority populations for prevention, in COP18 the portfolios are re-focused on the four largest metropolitan districts, which comprise 61% of targets for priority population prevention; 50% of targets for OVC; and 49% of targets for key populations. Priority populations for prevention were identified based on HIV risk profile, with highest priority focused on AGYW, men, OVC, and key populations. By reaching saturation of treatment and prevention interventions among key demographic populations in the highest burden districts, PEPFAR SA will disrupt HIV transmission and reduce HIV incidence.

Table 3.1 Current Status of ART saturation

Table 3.1 Current Status of ART saturation				
Prioritization Area	**Total PLHIV/% of all PLHIV for COP18**	**# Current on ART (FY2017)**	**# of Districts FY2018 (2017 COP)**	**# of Districts COP18 (FY2019)**
Attained	-	-	-	-
Scale-up Saturation	2,124,463 (35.3%)	1,105,438	4	4
Scale-up Aggressive	3,892,631 (52.4%)	2,052,527	23	23
Sustained	-	-	-	-
Central Support	1,406,993 (19.0%)	863,763	25	25

4.0 Program Activities for Epidemic Control in Scale-Up Locations and Populations

All PEPFAR SA investments support GoSA-led interventions, and are fully integrated into GoSA initiatives. In COP18 PEPFAR SA will invest in a range of targeted interventions to address identified barriers to epidemic control in the country, described in the sections that follow.

4.1 Finding the missing, getting them on treatment, and retaining them

A deep dive on the clinical cascade among older women reveals substantial linkage and retention gaps. To address these gaps, PEPFAR SA will substantially increase its facility- and community-level human resource investments to conduct HIV testing, enable same-day initiation, extended service hours, patient navigation, active linkage, adherence and retention tracking and tracing, and differentiated care.

PEPFAR will support a self-screening effort in COP18, backed by CHWs in priority districts. Partners will focus on populations that are not well reached by facility-based testing efforts.

To close the treatment gap among men, PEPFAR SA will support the GoSA to close case finding, linkage, and retention gaps through a diverse, complementary set of interventions including index testing, workplace testing, community-based testing, self-screening, community ART initiation through General Practitioner contracting, community medicine pick-up points, innovative peer-led approaches, and men-friendly services, including through extended service hours. PEPFAR SA is working with GoSA to fast-track the approval of the new HIV testing service (HTS) guidelines, which include self-screening.

Similarly, to close the treatment gap for youth in general and AGYW in particular, PEPFAR SA will close case finding, linkage, and retention gaps by leveraging facility, community, faith-based and traditional structures. PEPFAR SA will support the GoSA to expand adolescent and youth friendly services in facilities and communities, after-school hours, school health services, self-screening, youth connectors, youth care clubs, and mHealth (including social media). PEPFAR SA will work with the Department of Basic Education (DBE) and provincial and local authorities to accelerate roll-out of the comprehensive sexuality education (CSE) program, and the provision of school-based health services including HTS, in line with the National Adolescent and Youth Health Policy, issued in July 2017.

Case finding and clinical management remain the principal gaps in the clinical cascade for children. PEPFAR SA will utilize index testing, school health services, provider-initiated testing and counseling, nutrition and growth monitoring, and additional mentoring and support for pediatric case management (i.e., phlebotomy, dosing, viral load monitoring). PEPFAR SA will support the DoH to reach HIV-positive mothers with differentiated models of care that particularly respond to the needs of the mother-infant pair. In COP18 PEPFAR SA will fully support the National Health Screening, Testing and Treatment Campaign, which should result in a significant increase in new HIV treatment initiation.

Implementation of these evidence-based solutions will be optimized through a range of partner management and support strategies, including clear standard operating procedures (SOPs) tailored to local (facility and community) context. These strategies are further described in Section 4.5.

In addition, systems-level improvements included in COP18 will support accelerated and expanded ART coverage and retention for all populations. The NDoH released the same-day initiation circular in October 2017 with mixed implementation across the provinces—PEPFAR SA is currently engaging with provincial and district authorities to rapidly expand implementation of same-day initiation to all sites, and to all eligible patients. The core programmatic interventions will be further supported by health systems interventions including strengthened data quality and use, quality improvement, clinic-lab interface, health information systems, supply chain, and human resources for health planning and development. PEPFAR SA is currently supporting the DoH to implement the unique patient identifier policy and the Treatment and Retention Acceleration Plan SOP to improve data analytics and use at the facility, sub-district, district, provincial and national levels.

In COP18, PEPFAR SA will support the GoSA to scale up TB prevention and treatment among PLHIV. Priorities include increased HIV testing among individuals with presumptive TB and expanded screening for TB among PLHIV, ensuring ART for all TB/HIV co-infected individuals, and increasing TB preventive therapy.

In all these efforts, PEPFAR SA is committed to continue support for public health facilities, and to expand efforts in communities to improve case identification, linkage to ART, reduction in loss to follow-up, ART adherence, and other treatment support. These latter efforts will leverage the local knowledge and experience of FBOs and traditional structures. In addition, PEPFAR SA will increase its efforts to integrate mental health and substance abuse interventions across the prevention and treatment portfolios.

4.2 Prevention, specifically detailing programs for priority programming

In COP18, priority combination prevention investments continue to be promoted for AGYW, OVC, key populations and men (15-34 years), and will include increased use of peer-led prevention approaches to reach priority populations.

Adolescent girls and young women will be targeted with age-specific, multi-session, and layered prevention interventions. The new DBE policy on HIV, STIs and TB[23] creates substantial opportunities to scale up effective CSE interventions, and HIV and violence prevention in schools in the highest burden districts. As a result, PEPFAR SA has doubled its prevention targets for school-aged young people in COP18, and re-directed resources to support CSE scale-up. In addition to the current focus in seven districts (City of Johannesburg, eThekwini, Gert Sibande, Ehlanzeni, Thabo Mofutsanyane, City of Cape Town and King Cetshwayo), PEPFAR SA will expand CSE activities to priority schools in Nkangala, Ekurhuleni and uMgungundlovu in COP18.

[23] National Policy on HIV, STIs and TB for Learners, Educators, School Support Staff and Officials in all Primary and Secondary Schools in the Basic Education Sector, August 2017

In collaboration with the DBE and DoH, schools implementing CSE interventions will be linked to local health facilities offering adolescent and youth friendly services, and clinical PEPFAR partners, to increase the provision of biomedical SRH services, mixed contraception methods including condoms, STI screening and treatment, VMMC counseling and referral for services, HTS counseling, care and treatment services. Plans are also underway to support both DoH and DBE to improve the referral pathways and quality of services offered through the integrated school health program and to better align with the new DoH adolescent and youth health policy. PEPFAR is also supporting the DBE to develop the national implementation plan to fully implement the new policy, including appropriate resource allocation.

Among 9-14 year-old adolescent girls and boys, PEPFAR SA will leverage the OVC, school-based, safe spaces and community platforms using a combination of interventions to prevent sexual violence; delay sexual debut; support healthy choices; and empower parents, caregivers and communities to support, protect, and educate girls. Among adolescent girls 15-19 years, HIV prevention investments will leverage OVC, school-based, safe spaces, community, and clinical platforms using a combination of interventions to empower adolescent girls, strengthen families, mobilize communities, and link girls in this age group to SRH services including PrEP. Among young women 20-24 years, PEPFAR SA will leverage higher education [Technical and Vocational Education and Training colleges (TVETs) and universities], community and clinical platforms to prevent HIV by empowering young women, mobilizing communities, and linking young women to SRH including PrEP. The GoSA launched PrEP for TVET and university students in October 2017 and will launch PrEP for other AGYW in April 2018, to accelerate uptake in this critical population (COP18 targets for AGYW are doubled to >8,000). Investments in young women will also increase demand for services in both communities and facilities, and mobilize communities to support an end to violence against women.

In COP18, PEPFAR SA will continue to invest in comprehensive support to OVC through a family-centered case management approach. Through effective case management, household visits, and improved use of data and targeting, OVC implementing partners will identify the most vulnerable children (including AGYW) and provide one-on-one support that empowers them to stay in and progress in school; access health services and grants; be adherent and retained in care; reduce violence and abuse; and prevent new infections. In COP18, PEPFAR SA implementing partners will increase the delivery of an evidence-based package of services to beneficiaries 15-17 years of age especially girls. Implementing partners will also prioritize risk avoidance strategies for girls 9-14 years to ensure that they stay HIV-negative. In addition, the OVC portfolio of investments will have greater focus on prevention of GBV and improved linkages to post-violence care and post-exposure prophylaxis (PEP) as well as using post-violence care facilities as an entry point to maximize the potential to increase uptake of HIV interventions.

PEPFAR SA continues to strengthen its key population prevention investments targeted to female sex workers, men who have sex with men, transgender women, people who inject drugs, and inmates, aligned with strong country plans, and focused using rigorous population estimations. In

2016/2017, SANAC launched strategic plans for sex workers and lesbian, gay, bisexual, transgender and intersex people (LGBTI),[24] aligned with the NSP. These plans demonstrate strong consensus on the strategic direction and confirm GoSA support. The core of the COP18 program focuses on peer-led outreach and mobilization, targeted strategic communication and demand creation, and key population-friendly mobile and drop-in centers providing HIV, STI, and TB screening, testing and treatment services, and PrEP. This core package is complemented by interventions focused on stigma reduction, community mobilization, and use of strategic information for program management.

PEPFAR SA aims to reach 80% of males 15-34 years old in priority districts with VMMC services. Modeling has shown that targeting this age group is the most cost-effective in terms of infections averted. In COP18, PEPFAR SA will assist the GoSA to scale up the national VMMC program through planning, coordination, and implementation including advocacy, communication, and social mobilization. PEPFAR SA implements the WHO-recommended minimum package of services in public, private and non-governmental facilities in urban and rural communities with low rates of VMMC coverage and high HIV prevalence. PEPFAR SA will strengthen quality elements of the VMMC program through routine external quality assurance and continuous quality improvement activities. VMMC services will address harmful male norms and behaviors that may promote high-risk sexual behaviors, contribute to GBV, and limit access and/or adherence to HIV prevention services. The PEPFAR SA VMMC program will also strengthen linkage to treatment for men with HIV.

As noted above, in COP18 PEPFAR SA will increase its efforts to integrate mental health and substance abuse interventions across the prevention and treatment portfolios.

4.3 Additional country-specific priorities listed in the planning level letter

The PEPFAR SA COP18 planning level letter identified four priorities that must be addressed to increase the impact of PEPFAR investments in SA. Solutions to address these priorities have been identified as part of COP18 planning, and are described in other sections of this document, as indicated below.

1. Identification of greater efficiencies: Sections 4.5 and 7.0.
2. Increasing the focus of programming: Sections 3.0, 4.1 and 4.2.
3. Effective management of implementing partners: Section 4.5.
4. Support for implementation of critical policies: Sections 2.1, 4.1, 4.2 and 6.0.

[24] The South African National Sex Worker HIV Plan 2016-2019, and the South African National LGBTI HIV Plan 2017-2022.

4.4 Commodities

The GoSA invested approximately USD647 million for the procurement of HIV-related commodities in 2017/18. PEPFAR invested approximately USD25.4 million in HIV-related commodities in FY2017 and Global Fund invested USD10.6 million in 2016/17.[25]

In COP18 PEPFAR SA will invest USD65.7 million for ARVs, VMMC, laboratory consumables and other commodities to complement the GoSA's investment in the Treatment Surge. No other funding gaps for commodities have been projected for the period covered under COP18.

South Africa is geared up to transition to the Dolutegravir-based regimen in a phased approach started in 2018. A full transition to TLD will be initiated once formulations are registered by the South African Health Products Regulatory Authority.

4.5 Collaboration, Integration and Monitoring

In 2017 and 2018, significant gaps emerged in performance related to getting new PLHIV onto ART, and in keeping them on ART. PEPFAR SA, together with the NDoH, have and will continue to address these challenges with a range of strategic and management tools and approaches. These include the Treatment and Retention Acceleration Plan, SOPs for priority interventions, ensuring integration of systems interventions to gaps in the cascade, and aligning resources to HIV burden.

Underperformance by facilities and by implementing partners has and will continue to be addressed through management and technical interventions:

- PEPFAR SA, the NDoH, and the Provincial DoHs collaborated to develop and launch the Treatment and Retention Acceleration Plan in September 2017. The Plan provides a guide for weekly review of key data at the facility level and monthly review at the sub-district, district, provincial, and national levels. To ensure implementing partners share accountability for weekly facility reviews, implementing partners are reporting weekly data to PEPFAR SA. In COP18, PEPFAR SA will increase its investment in Data Capturers and health information systems to support these efforts.
- Beginning in FY2018, PEPFAR SA will intensify staff monitoring of the highest burden facilities in the highest burden districts through the 'Operation 10-10' strategy (i.e., 10 highest priority facilities in 10 highest burden districts). Modelled after best practices identified in PEPFAR Namibia, PEPFAR SA staff will actively monitor progress and address key barriers in these facilities/sites to ensure rapid course correction.
- To strengthen technical collaboration, PEPFAR SA and the NDoH jointly developed a protocol affirming shared responsibility for partner management through collaboration structures, actors, systems, and policies. PEPFAR SA institutionalized a monthly partner report that PEPFAR SA and the NDoH are using to track the progress of innovation projects, their adaptation and scale-up. The partner monthly report also allows

[25] All ARV expenditure data were calculated at the exchange rate of ZAR14.58:USD1. Information on HIV-related commodity expenditures crossed multiple fiscal years (April 2016-March 2018) due to availability of data.

implementing partners to provide actionable information on challenges and innovations to the NDoH.

- Building on this collaboration, PEPFAR SA and NDoH are jointly developing 40 SOPs to cover identified priority interventions across the HIV care cascade. These SOPs are designed to improve quality and efficiencies across community and facility sites, and to ensure that key interventions are delivered with fidelity and scaled optimally to address the identified barriers to performance. Examples of priority interventions include extended clinic hours, intensified case finding, self-screening, same-day ART initiation, adherence clubs and support groups. Monthly reporting will monitor the coverage and quality of these interventions across PEPFAR-supported facilities.
- To optimize the use of PEPFAR, GoSA, GFATM and other resources and to improve impact, PEPFAR SA will continue to collaborate with these important partners to ensure that resources are leveraged and that investments are planned to be complementary both technically and geographically. PEPFAR SA is working with the SANAC and GFATM Principal Recipients to harmonize interventions, indicators, and geographies aimed at preventing HIV and GBV among AGYW and key populations. These harmonization efforts are a result of strengthened collaborative relationships between PEPFAR SA staff and the GFATM Fund Portfolio Team (based in Geneva), the Country Coordinating Mechanism Secretariat (based at SANAC), and the Principal Recipients. PEPFAR SA, SANAC, and GFATM Principal Recipients are exploring opportunities to consolidate monitoring and evaluation and routine reporting tools (a health information system assessment is on-going to guide these decisions).

During the COP18 planning process, the PEPFAR SA team, in collaboration with staff from the USG Office of the Global AIDS Coordinator, critically reviewed above-site and above-service delivery activities to ensure they are mapped directly to key barriers and measurable outcomes. As a result of this deep dive, the PEPFAR SA team made significant adjustments to prioritize systems investments that will have the greatest impact on the epidemic. PEPFAR SA also further enhanced systems investments at the site level to monitor progress in human resources for health, clinic-lab interface, and supply chain.

4.6 Targets for scale-up locations and populations

Table 4.6.1 Entry Streams for Adults and Pediatrics Newly Initiating ART Patients in Scale-up Districts

Table 4.6.1 Entry Streams for Adults and Pediatrics Newly Initiating ART Patients in Scale-up Districts			
Entry Streams for ART Enrollment	**Tested for HIV (APR[a] FY2019) *HTS_TST***	**Newly Identified Positive (APR[a] FY2019) *HTS_TST_POS***	**Newly Initiated on ART (APR[a] FY2019) *TX_NEW***
Total Men	4,743,330	456,831	436,098
Total Women	4,867,549	509,537	495,198
Total Children (<15)	1,266,115	95,201	84,585
Adults			
TB Patients	88,882	41,760	35,721
Pregnant Women	623,308	90,730	105,449
VMMC clients	497,638	11,704	9363
Key populations	131,348	24,943	7,132
Priority Populations	N/A	N/A	N/A
Other Testing	8,326,882	809,826	813,425
Previously diagnosed and/or in care	*N/A*	*N/A*	50,735
Pediatrics (<15)			
HIV Exposed Infants	205,269	1,994	1,954
Other pediatric testing	1,236,040	91,809	84,582
Previously diagnosed and/or in care	*N/A*	*N/A*	*N/A*

[a] PEPFAR SA Annual Program Results.

Table 4.6.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts

Table 4.6.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts					
District	**Target Populations**	**Population Size Estimate (FY2019)**	**Current Coverage (FY2018 expected)**	***VMMC_CIRC* (in FY2018)**	**Expected Coverage (in FY2019)**
ec Alfred Nzo District Municipality	15-34 year olds	168,100	85%	11,851	88%
ec Amathole District Municipality	15-34 year olds	198,567	68%	5,318	74%
ec Buffalo City Metropolitan Municipality	15-34 year olds	142,408	90%	13,049	95%
ec Chris Hani District Municipality	15-34 year olds	159,718	74%	15,218	78%
ec Oliver Tambo District Municipality	15-34 year olds	300,113	81%	27,849	86%
fs Lejweleputswa District Municipality	15-34 year olds	125,220	77%	17,002	79%
fs Thabo Mofutsanyane District Municipality	15-34 year olds	151,827	65%	8,323	69%
gp City of Johannesburg Metropolitan Municipality	15-34 year olds	859,557	91%	24,997	91%
gp City of Tshwane Metropolitan Municipality	15-34 year olds	592,224	79%	4,130	79%

Table 4.6.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts					
District	**Target Populations**	**Population Size Estimate (FY2019)**	**Current Coverage (FY2018 expected)**	***VMMC_CIRC* (in FY2018)**	**Expected Coverage (in FY2019)**
gp Ekurhuleni Metropolitan Municipality	15-34 year olds	618,640	81%	10,260	81%
gp Sedibeng District Municipality	15-34 year olds	169,017	99%	5,999	99%
kz eThekwini Metropolitan Municipality	15-34 year olds	628,091	73%	133,075	95%
kz Harry Gwala District Municipality	15-34 year olds	97,091	70%	11,410	77%
kz King Cetshwayo District Municipality	15-34 year olds	168,877	87%	45,927	94%
kz Ugu District Municipality	15-34 year olds	156,182	85%	29,709	91%
kz uMgungundlovu District Municipality	15-34 year olds	210,846	72%	38,764	82%
kz Uthukela District Municipality	15-34 year olds	133,609	74%	23,937	78%
kz Zululand District Municipality	15-34 year olds	169,671	74%	35,934	79%
lp Capricorn District Municipality	15-34 year olds	255,731	112%	5,698	114%
lp Mopani District Municipality	15-34 year olds	224,461	106%	11,888	108%
mp Ehlanzeni District Municipality	15-34 year olds	319,273	91%	10,038	93%
mp Gert Sibande District Municipality	15-34 year olds	234,596	75%	15,895	78%
mp Nkangala District Municipality	15-34 year olds	311,809	96%	11,178	98%
nw Bojanala Platinum District Municipality	15-34 year olds	313,995	60%	10,814	69%
nw Dr Kenneth Kaunda District Municipality	15-34 year olds	131,751	67%	10,935	71%
nw Ngaka Modiri Molema District Municipality	15-34 year olds	184,581	56%	3,539	62%
wc City of Cape Town Metropolitan Municipality	15-34 year olds	689,147	53%	28,142	64%
TOTAL		**7,715,102**		**570,879**	

Table 4.6.3a Prevention Interventions to Facilitate Epidemic Control (DREAMS Districts)[a]

Table 4.6.3a Prevention Interventions to Facilitate Epidemic Control (DREAMS Districts)					
Target Populations	District (DREAMS)	Population Size Estimate (10-24 yrs)	FY2018 Coverage Goal [b]	FY2019 Target	FY2019 Coverage Goal [b]
AGYW (PP_PREV)	gp City of Johannesburg Metropolitan Municipality	585,725	14%	90,275	15%
	gp Ekurhuleni Metropolitan Municipality	419,109	9%	32,549	8%
	kz eThekwini Metropolitan Municipality	481,685	7%	76,413	16%
	kz uMgungundlovu District Municipality	167,316	14%	49,095	29%

[a] This table includes prevention interventions among AGYW. PP_PREV targets for non-DREAMS districts and for other priority populations are included in the Data Pack.

[b] Due to limited data on AGYW, the coverage goal is based on the total 10-24 year-old population, rather than on the vulnerable and at-risk individuals; as a result the coverage goal underestimates actual coverage of vulnerable and at-risk individuals. Coverage includes community- and school-based interventions.

Table 4.6.3b Prevention Interventions to Facilitate Epidemic Control (Key Populations)

Table 4.6.3b Prevention Interventions to Facilitate Epidemic Control (Key Populations)					
Target Populations	District	Population Size Estimate (2018) [a]	FY2018 Coverage Goal [b]	FY2019 Target	FY2019 Coverage Goal
Female Sex Workers (KP_PREV)	ec Oliver Tambo District Municipality	4,437	34%	3,328	75%
	gp City of Johannesburg Metropolitan Municipality	16,975	29%	13,580	80%
	gp City of Tshwane Metropolitan Municipality	11,326	23%	9,061	80%
	gp Ekurhuleni Metropolitan Municipality	6,701	42%	5,361	80%
	kz eThekwini Metropolitan Municipality	11,694	36%	6,992	60%
	kz uMgungundlovu District Municipality	2,071	59%	1,554	75%
	lp Vhembe District Municipality	2,757	63%	2,206	80%
	mp Ehlanzeni District Municipality	3,281	114%	2,461	75%
	mp Gert Sibande District Municipality	2,255	87%	1,691	75%
	mp Nkangala District Municipality	2,942	86%	2,206	75%
	nw Dr Kenneth Kaunda District Municipality	1,420	112%	1,065	75%
	wc City of Cape Town Metropolitan Municipality	13,561	39%	4,450	33%
Men who Have Sex with Men (KP_PREV)	ec Buffalo City Metropolitan Municipality	3,601	No targets	1,261	35%
	ec Nelson Mandela Bay Municipality	5,654	No targets	1,979	35%
	gp City of Johannesburg Metropolitan Municipality	47,549	31%	16,642	35%
	gp City of Tshwane Metropolitan Municipality	24,466	25%	6,116	25%
	gp Ekurhuleni Metropolitan Municipality	13,619	22%	2,405	18%
	kz eThekwini Metropolitan Municipality	27,394	25%	6,858	25%
	kz uMgungundlovu District Municipality	4,758	40%	2,190	46%
	mp Ehlanzeni District Municipality	7,311	No targets	1,828	25%
	wc City of Cape Town Metropolitan Municipality	29,901	40%	11,893	40%
Transgender Women (KP_PREV)	ec Buffalo City Metropolitan Municipality	830	No targets	415	50%
	ec Nelson Mandela Bay Municipality	1,260	No targets	630	50%
	gp City of Johannesburg Metropolitan Municipality	3,892	No targets	1,946	50%
	wc City of Cape Town Metropolitan Municipality	2,413	No targets	1,206	50%
People Who Inject Drugs (KP_PREV)	gp City of Tshwane Metropolitan Municipality	6,190	7%	4,333	70%
	mp Ehlanzeni District Municipality	1,744	No targets	1,221	70%
Inmates (KP_PREV)	National	157,013	45%	71,112	45%

[a] The GoSA and PEPFAR SA conduct routine triangulation of survey and program data to estimate population size and service coverage among key populations. Risks related to limitations in data availability and reliability, and the biases these limitations may introduce, are mediated through literature review and stakeholder consultation as part of the triangulation exercise.

[b] FY2018 coverage goals for key populations were developed using 2016 population estimates, but are presented here using the 2018 population estimates as the coverage denominator; as a result the FY2018 coverage goals appear variable. Coverage goals consider broader investments, including through GFATM.

Table 4.6.4 Targets for OVC and Linkages to HIV Services

Table 4.6.4 Targets for OVC and Linkages to HIV Services			
District	Estimated # of OVC	Target # of active OVC (FY2019Target) OVC_SERV	Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY2019 Target) OVC
gp City of Johannesburg Metro	154,382	116,500	100,190
kz eThekwini Metro	221,572	123,432	116,026
gp Ekurhuleni Metro	133,873	23,100	21,714
gp City of Tshwane Metro	90,469	51,000	45,900
mp Ehlanzeni District	135,560	36,984	34,765
wc City of Cape Town Metro	96,687	24,000	22,560
kz uMgungundlovu	88,618	32,000	29,440
nw Bojanala Platinum District	77,076	14,000	13,160
mp Gert Sibande District	88,571	34,257	32,202
ec Oliver Tambo District	252,601	8,000	7,520
kz King Cetshwayo District	99,107	10,060	9,456
kz Zululand District	104,278	8,000	7,520
gp Sedibeng District	47,649	15,000	14,100
mp Nkangala District	71,577	26,000	24,440
kz Ugu District	78,122	10,040	9,438
kz Uthukela District	75,420	10,105	9,499
fs Thabo Mofutsanyane District	69,372	10,000	9,400
lp Mopani District	81,600	9,315	8,756
lp Capricorn District	95,223	16,830	15,820
ec Alfred Nzo District	53,226	8,000	7,520
ec Buffalo City Metro	37,922	18,500	17,390
ec Amathole District	83,519	5,000	4,700
ec Chris Hani District	77,033	8,000	7,520
kz Harry Gwala District	55,785	10,040	9,438
TOTAL	**2,369,242**	**628,162**	**578,473**

5.0 Program Activities for Epidemic Control in Centrally Supported Locations and Populations

In COP18 PEPFAR will continue to focus for impact on the 27 highest burden districts. In addition, PEPFAR SA will continue to invest at central level in activities that support the 25 lower-burden districts. These investments are described in Section 6.0.

5.1 Targets for attained and centrally supported locations and populations

Table 5.1.1 Expected Beneficiary Volume Receiving Minimum Package of Services in Centrally Supported Districts

Table 5.2.2 Expected Beneficiary Volume Receiving Minimum Package of Services in Sustained Support Districts			
Sustained Support Volume by Group		**Expected result APR [a] FY2018**	**Expected result APR [a] FY2019**
HIV testing in PMTCT sites	*PMTCT_STAT*	*Targets not set*	*244,408*
HTS (only centrally supported ART sites in FY2017)	*HTS_TST/HTS_TST_POS*	*Targets not set*	*1,938,195* [b] */ 123,948*
Current on ART	*TX_CURR*	*Targets not set*	1,051,273 [c]
OVC	*OVC_SERV*	*Not applicable*	*Not applicable*

[a] PEPFAR SA Annual Program Results

[b] Excludes PMTCT_STAT and EID

[c] TX_CURR for <15 and 15+

6.0 Systems Support Necessary to Achieve Sustained Epidemic Control

Systems support investments are activities designed to strengthen components of the health system considered essential to the successful implementation of HIV prevention, care and treatment programs. These activities are implemented above the site and service delivery levels, and are linked to the SID scores. In COP18, PEPFAR SA systems investments include (1) host country institutional development; (2) supply chain systems; (3) technical area guidelines and tools; (4) targeted assessments, evaluation and operations research; (5) surveys and surveillance; (6) costing and efficiency analyses; (7) financial management policies and procedures; (8) information, education and communication and/or demand creation; information systems; (9) management and coordination; (10) workforce development, pre-service training; and (11) clinics and laboratory accreditation.

All COP18 health systems activities support achievement of sustained epidemic control in SA. PEPFAR SA will invest in systems supportive of the Treatment Surge, in information systems that help link patients to care, monitor progress, and drive broader program achievements, and in evidence-based technical guidelines and policies that improve program impact and efficiencies.

The Treatment Surge will require an expansion of current and alternative service delivery models, including into communities in facility catchment areas. In COP18, PEPFAR SA will substantially increase systems-level investments to improve the CCMDD program. Expanding health services into the community requires an enabling environment for CHWs. PEPFAR SA is working closely

with NDoH to develop supportive policy and operational systems to ensure high quality, appropriate care is provided with regular communication to and from facilities. CHWs will play a vital role in index case finding, HIV counseling and testing, linkage to ART initiation and adherence to HIV treatment. In COP18, PEPFAR SA will increase its investment in Human Resource Information Systems to track health care workers, starting with CHWs. Data will be used to optimize staff allocation (both DoH staff and those funded through PEPFAR SA), ensuring human resources are placed where they are most needed. Investments in provincial data centers will integrate TIER.Net with other key databases (including NHLS) using unique patient identifier, and greatly improve the ability to link patients to care, monitor progress, support program management and optimize resource allocation.

COP18 will support the NDoH to efficiently roll out TLD, providing technical support to the planning, implementation and supply chain monitoring. Key investments include policy development, costing, procurement and distribution systems to ensure continuous stock availability, and consumption of existing ARVs (no wastage) during the transition.

The majority of HIV services in South Africa are delivered in the primary care system. In COP18 PEPFAR SA will continue to support targeted initiatives in the primary care system, leveraging ongoing GoSA efforts to improve service quality and accessibility. These initiatives include the upcoming National Health Screening, Testing and Treatment Campaign, and the strategic use of HIV Primary Health Care indicators (such as TB rates) to inform PEFPAR response and training.

Systems investments are designed to address the most critical systems-based barriers that inhibit epidemic control in SA. These gaps were identified through a range of strategic processes, including the NSP, the national SID 3.0, the PEPFAR Monitoring, Evaluation and Reporting system, and Site Improvement through Monitoring System (SIMS). The investments have been aligned with those of the GoSA and with other development partners, and in particular the GFATM, to optimize opportunities to leverage and complement and to ensure the best return on these investments. Benchmarks of progress are established for each of the funded activities and will be monitored regularly to ensure that activities are on track and continue to address barriers to the success of the broader portfolio.

The list of COP18 investments designed to support the broader SA HIV program are included in summary form as Appendix C.

7.0 Staffing Plan

Staffing Optimization

During 2017, PEPFAR South Africa implementing agencies undertook a formal "staffing optimization" exercise to ensure that all USG agencies implementing PEPFAR SA programs were staffed for efficiency and success. These exercises used structured approaches to assess current staffing and organization, roles for each staff member, reporting lines and barriers to effective implementation. The exercise resulted in important changes to agency-specific and interagency organizational structures to optimize efficiency and effectiveness to achieve program pivots. The following changes are particularly noteworthy:

- To rationalize responsibilities for interagency business processes, proactive agency partner management, and technical roles, PEPFAR SA interagency staff are organized into and assigned specific roles through Core Interagency Teams. These teams cover program areas and critical targeted populations, including AGYW and men.
- Interagency staff are assigned as provincial points of contact to coordinate the monitoring, support and trouble-shooting at provincial level to improve district- and facility-level outcomes.
- To meet SIMS requirements in COP18, agencies have clarified the expectation that eligible staff invest approximately 15% of their time conducting SIMS visits.
- Agency staff responsible for managing the contracts and cooperative agreements of implementing partners now play a more active role to aggressively manage implementing partners for success. These strategies are further described in Section 4.5.

APPENDIX A – Prioritization

Table A.1.1 Treatment Coverage by Age, Sex and District, by District Prioritization, DREAMS Districts (fine age bands)

Table A.1.1 Treatment Coverage by Age, Sex and District, by District Prioritization, DREAMS Districts (fine age bands)											
District	COP	Prioritization	Results Reported	*Attained:90-90-90 (81%) by each age and sex band to reach 95-95-95 (90%) overall*						Overall ART Coverage (PEPFAR)	Coverage: Reported/ Expected
				10-14 years		15-24 years		25+ years			
				F	M	F	M	F	M		
gp City of Johannesburg Metropolitan Municipality	COP 16	Scale-Up Saturation	APR 17	31%	30%	48%	95%	71%	54%	61%	reported
	COP 17	Scale-Up Saturation	APR 18 Q1	28%	26%	25%	32%	74%	55%	82%	reported
	COP 18	Scale-Up Saturation	APR 19	67%	63%	105%	108%	96%	97%	81%	expected
gp Ekurhuleni Metropolitan Municipality	COP 16	Scale-Up Saturation	APR 17	28%	25%	30%	27%	77%	53%	63%	reported
	COP 17	Scale-Up Saturation	APR 18 Q1	29%	25%	30%	28%	79%	54%	81%	reported
	COP 18	Scale-Up Saturation	APR 19	64%	56%	117%	120%	107%	108%	81%	expected
kz eThekwini Metropolitan Municipality	COP 16	Scale-Up Saturation	APR 17	39%	31%	49%	101%	69%	56%	65%	reported
	COP 17	Scale-Up Saturation	APR 18 Q1	33%	31%	44%	54%	74%	58%	92%	reported
	COP 18	Scale-Up Saturation	APR 19	62%	59%	92%	94%	84%	87%	81%	expected
kz uMgungundlovu District Municipality	COP 16	Scale-Up Saturation	APR 17	45%	34%	64%	203%	59%	58%	64%	reported
	COP 17	Scale-Up Saturation	APR 18 Q1	22%	23%	57%	82%	72%	56%	81%	reported
	COP 18	Scale-Up Saturation	APR 19	69%	73%	114%	119%	91%	98%	74%	expected

Table A.1.2 Treatment Coverage by Age, Sex and District, by District Prioritization (coarse age bands)

Table A.1.2 Treatment Coverage by Age, Sex and District, by District Prioritization (coarse age bands)									
District	COP	Prioritization	Results Reported	*Attained:90-90-90 (81%) by each age and sex band to reach 95-95-95 (90%) overall*					
				10-14 years		15+ years		Overall ART Coverage (PEPFAR)	Coverage: Reported/ Expected
				F	M	F	M		
gp City of Johannesburg Metropolitan Municipality	COP 16	Scale-Up Saturation	APR 17	31%	30%	67%	56%	61%	reported
	COP 17	Scale-Up Saturation	APR 18 Q1	28%	26%	66%	54%	82%	reported
	COP 18	Scale-Up Saturation	APR 19	67%	63%	97%	98%	81%	expected
gp Ekurhuleni Metropolitan Municipality	COP 16	Scale-Up Saturation	APR 17	28%	25%	69%	51%	63%	reported
	COP 17	Scale-Up Saturation	APR 18 Q1	29%	25%	70%	53%	81%	reported
	COP 18	Scale-Up Saturation	APR 19	64%	56%	108%	109%	81%	expected
kz eThekwini Metropolitan Municipality	COP 16	Scale-Up Saturation	APR 17	39%	31%	66%	59%	65%	reported
	COP 17	Scale-Up Saturation	APR 18 Q1	33%	31%	70%	58%	92%	reported
	COP 18	Scale-Up Saturation	APR 19	62%	59%	85%	88%	81%	expected
kz uMgungundlovu District Municipality	COP 16	Scale-Up Saturation	APR 17	45%	34%	60%	68%	64%	reported
	COP 17	Scale-Up Saturation	APR 18 Q1	22%	23%	70%	58%	81%	reported
	COP 18	Scale-Up Saturation	APR 19	69%	73%	94%	100%	74%	expected
ec Alfred Nzo District Municipality	COP 16	Scale-Up Aggressive	APR 17	33%	36%	65%	46%	60%	reported
	COP 17	Scale-Up Aggressive	APR 18 Q1	15%	16%	70%	49%	81%	reported
	COP 18	Scale-Up Aggressive	APR 19	22%	24%	80%	82%	73%	expected
ec Amathole District Municipality	COP 16	Scale-Up Aggressive	APR 17	16%	18%	52%	35%	49%	reported
	COP 17	Scale-Up Aggressive	APR 18 Q1	17%	19%	56%	39%	81%	reported
	COP 18	Scale-Up Aggressive	APR 19	23%	25%	66%	68%	73%	expected
ec Buffalo City Metropolitan Municipality	COP 16	Scale-Up Aggressive	APR 17	132%	146%	53%	67%	58%	reported
	COP 17	Scale-Up Aggressive	APR 18 Q1	28%	29%	65%	44%	81%	reported
	COP 18	Scale-Up Aggressive	APR 19	70%	72%	80%	80%	73%	expected
ec Chris Hani District Municipality	COP 16	Scale-Up Aggressive	APR 17	36%	28%	33%	88%	50%	reported
	COP 17	Scale-Up Aggressive	APR 18 Q1	17%	12%	51%	55%	81%	reported
	COP 18	Scale-Up Aggressive	APR 19	55%	39%	78%	80%	73%	expected

Table A.1.2 Treatment Coverage by Age, Sex and District, by District Prioritization (coarse age bands)									
District	COP	Prioritization	Results Reported	*Attained:90-90-90 (81%) by each age and sex band to reach 95-95-95 (90%) overall*				Overall ART Coverage (PEPFAR)	Coverage: Reported/ Expected
				10-14 years		15+ years			
				F	M	F	M		
ec Oliver Tambo District Municipality	COP 16	Scale-Up Aggressive	APR 17	32%	25%	37%	106%	58%	reported
	COP 17	Scale-Up Aggressive	APR 18 Q1	14%	11%	61%	62%	81%	reported
	COP 18	Scale-Up Aggressive	APR 19	35%	27%	81%	84%	73%	expected
fs Lejweleputswa District Municipality	COP 16	Scale-Up Aggressive	APR 17	74%	38%	62%	50%	67%	reported
	COP 17	Scale-Up Aggressive	APR 18 Q1	70%	12%	62%	68%	81%	reported
	COP 18	Scale-Up Aggressive	APR 19	57%	10%	84%	92%	75%	expected
fs Thabo Mofutsanyane District Municipality	COP 16	Scale-Up Aggressive	APR 17	44%	100%	64%	81%	72%	reported
	COP 17	Scale-Up Aggressive	APR 18 Q1	25%	26%	79%	62%	81%	reported
	COP 18	Scale-Up Aggressive	APR 19	43%	46%	81%	89%	75%	expected
gp City of Tshwane Metropolitan Municipality	COP 16	Scale-Up Aggressive	APR 17	46%	44%	49%	49%	51%	reported
	COP 17	Scale-Up Aggressive	APR 18 Q1	19%	18%	58%	41%	81%	reported
	COP 18	Scale-Up Aggressive	APR 19	103%	95%	84%	85%	81%	expected
gp Sedibeng District Municipality	COP 16	Scale-Up Aggressive	APR 17	54%	53%	64%	53%	63%	reported
	COP 17	Scale-Up Aggressive	APR 18 Q1	28%	30%	68%	56%	81%	reported
	COP 18	Scale-Up Aggressive	APR 19	91%	98%	109%	111%	72%	expected
kz Harry Gwala District Municipality	COP 16	Scale-Up Aggressive	APR 17	36%	41%	59%	60%	59%	reported
	COP 17	Scale-Up Aggressive	APR 18 Q1	18%	19%	66%	51%	81%	reported
	COP 18	Scale-Up Aggressive	APR 19	30%	32%	84%	87%	74%	expected
kz King Cetshwayo District Municipality	COP 16	Scale-Up Aggressive	APR 17	43%	45%	71%	57%	68%	reported
	COP 17	Scale-Up Aggressive	APR 18 Q1	21%	23%	75%	60%	81%	reported
	COP 18	Scale-Up Aggressive	APR 19	34%	37%	86%	81%	74%	expected
kz Ugu District Municipality	COP 16	Scale-Up Aggressive	APR 17	46%	56%	72%	62%	70%	reported
	COP 17	Scale-Up Aggressive	APR 18 Q1	24%	31%	75%	63%	81%	reported
	COP 18	Scale-Up Aggressive	APR 19	35%	46%	79%	97%	74%	expected
kz Uthukela District	COP 16	Scale-Up Aggressive	APR 17	52%	39%	40%	96%	60%	reported

Table A.1.2 Treatment Coverage by Age, Sex and District, by District Prioritization (coarse age bands)									
District	COP	Prioritization	Results Reported	*Attained:90-90-90 (81%) by each age and sex band to reach 95-95-95 (90%) overall*				Overall ART Coverage (PEPFAR)	Coverage: Reported/ Expected
				10-14 years		15+ years			
				F	M	F	M		
Municipality	COP 17	Scale-Up Aggressive	APR 18 Q1	22%	21%	69%	47%	81%	reported
	COP 18	Scale-Up Aggressive	APR 19	30%	29%	80%	76%	74%	expected
kz Zululand District Municipality	COP 16	Scale-Up Aggressive	APR 17	42%	29%	72%	78%	64%	reported
	COP 17	Scale-Up Aggressive	APR 18 Q1	22%	9%	66%	68%	85%	reported
	COP 18	Scale-Up Aggressive	APR 19	41%	16%	95%	99%	74%	expected
lp Capricorn District Municipality	COP 16	Scale-Up Aggressive	APR 17	39%	44%	52%	76%	58%	reported
	COP 17	Scale-Up Aggressive	APR 18 Q1	13%	16%	64%	48%	81%	reported
	COP 18	Scale-Up Aggressive	APR 19	18%	22%	68%	71%	73%	expected
lp Mopani District Municipality	COP 16	Scale-Up Aggressive	APR 17	28%	32%	93%	62%	82%	reported
	COP 17	Scale-Up Aggressive	APR 18 Q1	27%	32%	93%	63%	90%	reported
	COP 18	Scale-Up Aggressive	APR 19	33%	39%	74%	77%	73%	expected
mp Ehlanzeni District Municipality	COP 16	Scale-Up Aggressive	APR 17	58%	62%	68%	64%	68%	reported
	COP 17	Scale-Up Aggressive	APR 18 Q1	31%	32%	83%	48%	81%	reported
	COP 18	Scale-Up Aggressive	APR 19	42%	43%	78%	81%	71%	expected
mp Gert Sibande District Municipality	COP 16	Scale-Up Aggressive	APR 17	38%	38%	62%	46%	60%	reported
	COP 17	Scale-Up Aggressive	APR 18 Q1	21%	22%	68%	50%	81%	reported
	COP 18	Scale-Up Aggressive	APR 19	40%	43%	81%	85%	71%	expected
mp Nkangala District Municipality	COP 16	Scale-Up Aggressive	APR 17	47%	49%	55%	59%	56%	reported
	COP 17	Scale-Up Aggressive	APR 18 Q1	18%	19%	64%	44%	81%	reported
	COP 18	Scale-Up Aggressive	APR 19	33%	34%	68%	71%	71%	expected
nw Bojanala Platinum District Municipality	COP 16	Scale-Up Aggressive	APR 17	28%	23%	63%	44%	57%	reported
	COP 17	Scale-Up Aggressive	APR 18 Q1	28%	23%	64%	45%	81%	reported
	COP 18	Scale-Up Aggressive	APR 19	64%	52%	82%	89%	74%	expected
nw Dr Kenneth Kaunda District Municipality	COP 16	Scale-Up Aggressive	APR 17	222%	176%	85%	69%	67%	reported
	COP 17	Scale-Up Aggressive	APR 18 Q1	142%	90%	79%	62%	81%	reported

Table A.1.2 Treatment Coverage by Age, Sex and District, by District Prioritization (coarse age bands)									
District	COP	Prioritization	Results Reported	*Attained:90-90-90 (81%) by each age and sex band to reach 95-95-95 (90%) overall*				Overall ART Coverage (PEPFAR)	Coverage: Reported/ Expected
				10-14 years		15+ years			
				F	M	F	M		
	COP 18	Scale-Up Aggressive	APR 19	234%	149%	74%	78%	74%	expected
nw Ngaka Modiri Molema District Municipality	COP 16	Scale-Up Aggressive	APR 17	19%	21%	50%	41%	48%	reported
	COP 17	Scale-Up Aggressive	APR 18 Q1	20%	21%	52%	42%	81%	reported
	COP 18	Scale-Up Aggressive	APR 19	57%	44%	72%	78%	74%	expected
wc City of Cape Town Metropolitan Municipality	COP 16	Scale-Up Aggressive	APR 17	56%	40%	49%	62%	58%	reported
	COP 17	Scale-Up Aggressive	APR 18 Q1	24%	21%	59%	57%	81%	reported
	COP 18	Scale-Up Aggressive	APR 19	46%	40%	61%	101%	70%	expected
ec Joe Gqabi District Municipality	COP 16	Central Support	APR 19	N/A: No target required				73%	expected
ec Nelson Mandela Bay Municipality	COP 18	Central Support	APR 19	N/A: No target required				73%	expected
ec Sarah Baartman District Municipality	COP 18	Central Support	APR 19	N/A: No target required				73%	expected
fs Fezile Dabi District Municipality	COP 18	Central Support	APR 19	N/A: No target required				75%	expected
fs Mangaung Metropolitan Municipality	COP 18	Central Support	APR 19	N/A: No target required				75%	expected
fs Xhariep District Municipality	COP 18	Central Support	APR 19	N/A: No target required				75%	expected
gp West Rand District Municipality	COP 18	Central Support	APR 19	N/A: No target required				72%	expected
kz Amajuba District Municipality	COP 18	Central Support	APR 19	N/A: No target required				74%	expected
kz iLembe District Municipality	COP 18	Central Support	APR 19	N/A: No target required				74%	expected
kz Umkhanyakude District Municipality	COP 18	Central Support	APR 19	N/A: No target required				74%	expected
kz Umzinyathi District Municipality	COP 18	Central Support	APR 19	N/A: No target required				74%	expected
lp Sekhukhune District Municipality	COP 18	Central Support	APR 19	N/A: No target required				73%	expected

Table A.1.2 Treatment Coverage by Age, Sex and District, by District Prioritization (coarse age bands)									
District	COP	Prioritization	Results Reported	*Attained:90-90-90 (81%) by each age and sex band to reach 95-95-95 (90%) overall*				Overall ART Coverage (PEPFAR)	Coverage: Reported/ Expected
				10-14 years		15+ years			
				F	M	F	M		
lp Vhembe District Municipality	COP 18	Central Support	APR 19	N/A: No target required				73%	expected
lp Waterberg District Municipality	COP 18	Central Support	APR 19	N/A: No target required				73%	expected
nc Frances Baard District Municipality	COP 18	Central Support	APR 19	N/A: No target required				74%	expected
nc John Taolo Gaetsewe District Municipality	COP 18	Central Support	APR 19	N/A: No target required				74%	expected
nc Namakwa District Municipality	COP 18	Central Support	APR 19	N/A: No target required				74%	expected
nc Pixley ka Seme District Municipality	COP 18	Central Support	APR 19	N/A: No target required				74%	expected
nc Zwelentlanga Fatman Mgcawu District Municipality	COP 18	Central Support	APR 19	N/A: No target required				74%	expected
nw Dr Ruth Segomotsi Mompati District Municipality	COP 18	Central Support	APR 19	N/A: No target required				74%	expected
wc Cape Winelands District Municipality	COP 18	Central Support	APR 19	N/A: No target required				70%	expected
wc Central Karoo District Municipality	COP 18	Central Support	APR 19	N/A: No target required				70%	expected
wc Eden District Municipality	COP 18	Central Support	APR 19	N/A: No target required				70%	expected
wc Overberg District Municipality	COP 18	Central Support	APR 19	N/A: No target required				70%	expected
wc West Coast District Municipality	COP 18	Central Support	APR 19	N/A: No target required				70%	expected

Table A.2 ART Targets by Prioritization for Epidemic Control

Table A.2 ART Targets by Prioritization for Epidemic Control						
Prioritization Area	**Total PLHIV (Estimated at end of FY2018)**	**Expected current on ART (APR[a] FY2018)**	**Additional patients required for 80% ART coverage**	**Target current on ART (APR[a] FY2019) *TX_CURR***	**Newly initiated (APR[a] FY2019) *TX_NEW***	**ART Coverage (APR[a] FY2019)**
Attained	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Scale-Up Saturation	**2,097,527**	**1,397,221**	**280,801**	**1,703,186**	**406,422**	**81%**
Scale-Up Aggressive	**3,840,276**	**2,411,398**	**660,822**	**2,854,762**	**608,270**	**74%**
Sustained	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Central Support	**1,389,970**	**913,426**	**198,550**	**1,007,511**	**149,164**	**72%**
Total	**7,327,773**	**4,722,045**	**1,140,173**	**5,565,459**	**1,163,856**	

[a] PEPFAR SA Annual Program Results

APPENDIX B – Budget Profile and Resource Projections

B.1 COP 18 Planned Spending

Table B.1.1 COP18 Budget by Approach and Program Area (USD)

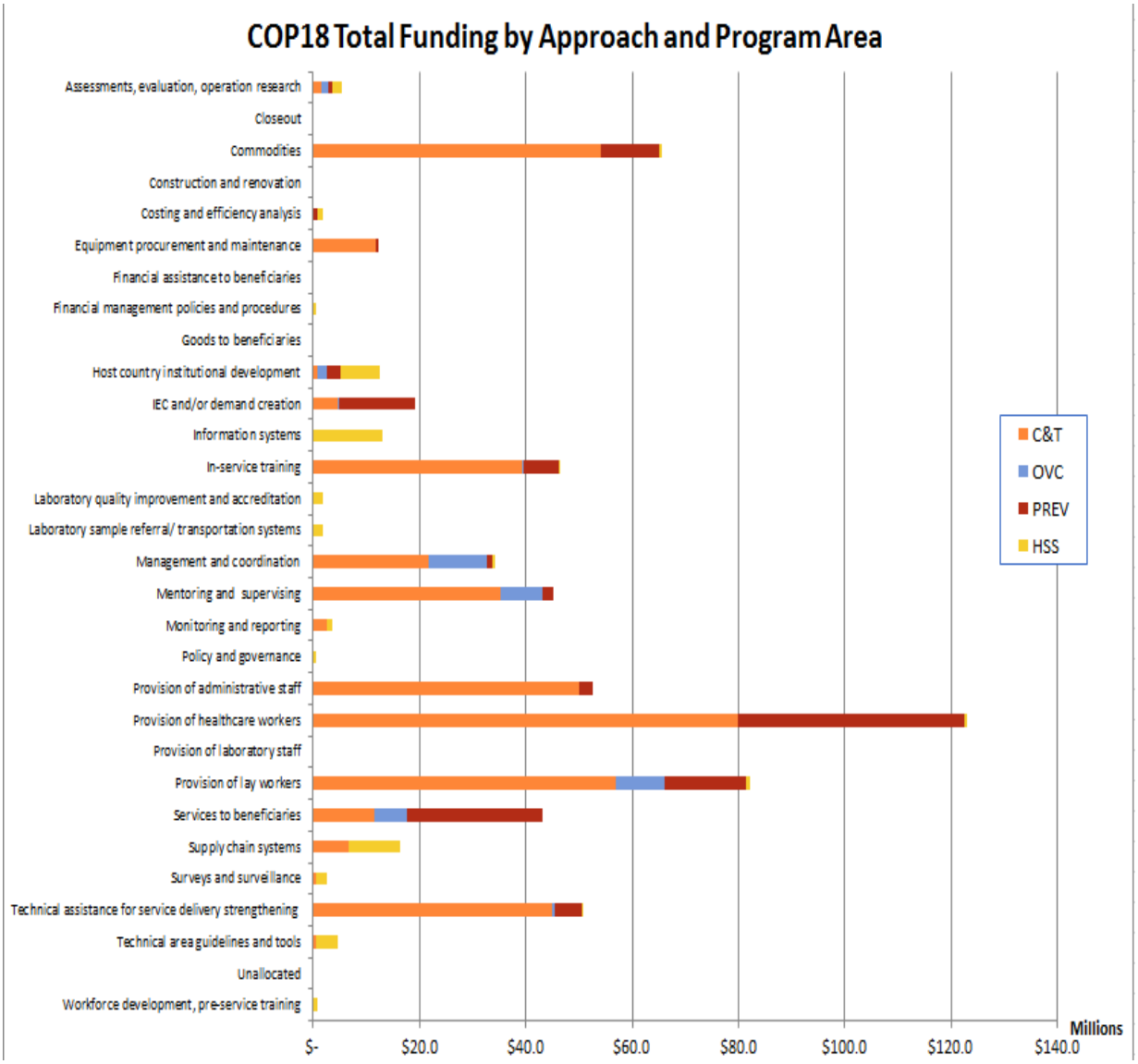


Table B.1.2 COP 18 Total Planning Level

Table B.1.2 COP 18 Total Planning Level		
Applied Pipeline (USD)	**New Funding (USD)**	**Total Spend (USD)**
4,610,026	**572,355,198**	**576,965,224**

Table B.1.3 Resource Allocation by PEPFAR Budget Code (new funds only)

Table B.1.3 Resource Allocation by PEPFAR Budget Code (new funds only)		
PEPFAR Budget Code	**Budget Code Description**	**Amount Allocated (USD)**
MTCT	Mother-to-Child Transmission	10,556,907
HVAB/Y	Abstinence/Be Faithful Prevention/Youth	8,702,585
HVOP	Other Sexual Prevention	31,397,797
IDUP	Injecting and Non-Injecting Drug Use	344,438
HMBL	Blood Safety	-
HMIN	Injection Safety	-
CIRC	Male Circumcision	59,853,277
HVCT	Counseling and Testing	38,747,897
HBHC	Adult Care and Support	42,638,634
PDCS	Pediatric Care and Support	13,898,100
HKID	Orphans and Vulnerable Children	38,347,943
HTXS	Adult Treatment	177,692,138
HTXD	ARV Drugs	10,291,326
PDTX	Pediatric Treatment	26,244,502
HVTB	TB/HIV Care	45,840,548
HLAB	Lab	6,736,891
HVSI	Strategic Information	20,245,638
OHSS	Health Systems Strengthening	27,344,443
HVMS	Management and Operations	13,472,136
TOTAL		**572,355,200**

B.2 Resource Projections

All COP18 budget planning was completed using the Funding Allocation to Strategy Tool. The resource projections used estimated service package costs, unit expenditures and budgets for site-level and above-site activities.

APPENDIX C – Tables and Systems Investments for Section 6.0

Table 6 Summary of Systems Investments, COP18

Implementing Partner Name	Type of Investment	COP18 Activity	Expected Outcome	Expected Timeline for Achievement of Outcome
To be Determined	Assessments, evaluation, operation research	HIV and TB operational research	Generate data driven evidence to help improve policies and programs.	3 years
MatCH	Assessments, evaluation, operation research	Evaluation on performance, process and outcome of CHW and FBO interventions in the PEPFAR SA Surge	Improved approaches adapted and implemented that use results of the assessment of linkage to care, adherence to treatment, retention in care and viral suppression associated with the CHW- and FBO-interventions.	3 years
MEASURE Evaluation Phase IV	Assessments, evaluation, operation research	Finalize an evaluation of the effectiveness of CSE to inform national program scale up	Local evidence available for implementing CSE.	1 year
Tulane University	Assessments, evaluation, operation research	Track OVC cohorts over three years to examine changes in HIV risk factors and behaviors over three years (provide combination of evidence–based interventions to OVC to remain HIV negative/link HIV+ to Care and Treatment).	Develop and implement a rigorous monitoring and evaluation system which enables pre and post intervention outcome tracking to examine changes in HIV risk factors and behaviors of OVC over a period of time.	3 Years
FHI-360: ASPIRES	Assessments, evaluation, operation research	Finalize a randomized study evaluating an intervention integrating economic strengthening and HIV prevention programs for vulnerable youth in South Africa	Endline randomized study evaluation report with detailed findings and recommendations on the integrated economic strengthening and HIV prevention program. The evidence from the study will inform and shape OVC programming focusing on economic strengthening and HIV prevention.	1 year

Implementing Partner Name	Type of Investment	COP18 Activity	Expected Outcome	Expected Timeline for Achievement of Outcome
National Health Laboratory Services	Clinics and Laboratory quality improvement and accreditation/ Surveys and Surveillance	Support all aspects of a quality lab system in support of an HIV treatment surge	All sites perform HTS in the 27 priority districts (2300 sites) are enrolled in the RTCQI/CLI program and are at level 4/5 of the checklist; sites perform HTS are enrolled in PT and IQC and are passing the last round of PT; All VL/EID labs and TB Xpert labs are accredited; 100% of facilities have access to the Results For Action (RFA) report; 90% of facilities are using the specimens' tracking system (eLab); Data available for dissemination from annual surveys.	3 years
To be Determined	Costing and efficiency analysis	Cost and budget modeling	Support GoSA by developing and expanding national cost models to inform planning and budgeting and generating information to improve policy and guideline decisions.	3 years
Education Development Center	Costing and efficiency analysis	Costing and budget modelling to inform the allocation of resources for Comprehensive Sexual Education (CSE) and school health services	Department of Basic Education and DoH include funding for CSE in MTF budget or conditional grant budget.	1 year
To be Determined	Financial management policies and procedures	Cost and budget technical assistance	Support GoSA by developing and expanding national cost models to inform planning and budgeting and generating information to improve policy and guideline decisions.	3 years
SANAC	Host country institutional development	M&E Technical support to provinces, with focus on improving data engagement across multiple sectors within provinces and districts	Improved competence and aptitude of sub-national government offices to effectively utilize and respond to routinely collected program data for purposes of program improvement, with goal of accelerating progress toward epidemic control.	2 years
Wits RHI	Host country institutional development	Support NDOH to implement evidence-informed HIV prevention care and treatment programs for adolescent girls and young women (AGYW)	Reduced HIV Incidence and teenage pregnancy. Increased AGYW-friendly services uptake.	2 years

Implementing Partner Name	Type of Investment	COP18 Activity	Expected Outcome	Expected Timeline for Achievement of Outcome
National Department of Health	Host country institutional development	Help NDoH implement facility and community risk assessment tool; Support NDoH to provide effective user support via the national help desk; Second staff and support key activities in a collaboration of strategic importance in TB/HIV care among women and infants in antenatal care; Training and monitoring of clinical staff for mother/infant pairs; management of the CHW and CCMDD programs; Provide technical assistance and implementation of health information systems to provinces.	Policy change regarding integration of HIV/TB services in ANC settings; Improved infant testing, linkage, adherence, retention and VLS of children; Effective coordination, management, and monitoring of the CHW and CCMDD programs.	3 years
Council for Scientific and Industrial Research (CSIR)	Host country institutional development	Provide technical assistance to NDoH to update, develop, and implement facility and community risk assessment tool and implement IC guidelines in health facilities, households and congregate settings; support the DoH to conduct surveillance of TB among health workers; Design and develop mechanical sputum booth, Train and mentor NDoH healthcare workers on IC activities	Reduction in TB incident cases among PLHIV in South Africa.	3 years
South African National AIDS Council	Host country institutional development	Coordination of all AGYW prevention programs in line with the She Conquers national strategy	Improved alignment of AGYW programs in South Africa; increased uptake among AGYW from various AGYW-focused programs.	3 years
Pact, Inc.	Host country institutional development	Support Department of Social Development to update the supervision framework, and practice guidelines developed to ensure that beneficiaries receive quality, accessible, adolescent-friendly services through the DSD service points and NPOs	Develop and operationalize guidelines for social service practitioners to support access and referrals to HIV services.	1 year
To be Determined	Host country institutional development	Develop an implementation framework for the 2017 DBE National Policy on HIV, STIs and TB	Improved implementation of CSE and school health services.	2 years

Implementing Partner Name	Type of Investment	COP18 Activity	Expected Outcome	Expected Timeline for Achievement of Outcome
Education Development Center	Host country institutional development	ii) Support development of materials for district TOTs ii) Conduct TOTs for DBE district teams responsible for rolling out the CSE policy	Improved implementation of CSE and health services.	1 year
FPD	IEC and/or demand creation	Support scale-up of treatment initiation, adherence, and retention through development of psychosocial, peer-to-peer tools and communication for PLHIV and health care providers	Improved outcomes for PLHIV (initiation, adherence, retention).	2 years
Johns Hopkins Health & Education in SA	IEC and/or demand creation	Implement above-the-line communication activities targeting men 14-34 years old in 12 priority districts with VMMC messages to address barriers and fears men have towards circumcision.	204,196 men in 12 priority districts medically circumcised by September 30, 2019.	1 year
To be Determined	IEC and/or demand creation	Support DBE and DoH to develop a national CSE demand creation strategy for youth groups	Improved implementation of CSE and health services.	1 year
University Research Corp (URC)	IEC and/or demand creation	Implement district-level and site-level VMMC demand creation activities targeting men 14-34 years old in 12 districts	204,196 men in 12 priority districts medically circumcised by September 30, 2019.	1 year
To be Determined	IEC and/or demand creation	Sensitization and refresher training of district level SA government and CBO officials that are responsible for preventing or responding to GBV	Improved rates of reporting of GBV cases within health and legal systems as a result of better treatment in health and legal systems.	2 years
To be Determined	IEC and/or demand creation	Use innovative and age appropriate media and technology to increase demand for community based GBV services	Improved rates of reporting of GBV at CHC level and strong linkage to medico-legal services.	3 years
To be Determined	IEC and/or demand creation	Develop capacity of community health care center staff to receive and treat rape survivors , with SAG support	Increase reporting of GBV at community health centers.	3 years
To be Determined	IEC and/or demand creation	Implement VMMC demand creation activities targeting uncircumcised males aged 15-34 years	Increased VMMC coverage across priority districts and reduced HIV incidence.	1 year

Implementing Partner Name	Type of Investment	COP18 Activity	Expected Outcome	Expected Timeline for Achievement of Outcome
Digital Square	Information Systems	Develop and implement provincial data exchange platforms with advanced automated data analytics and tools	- All provinces have a provincial data center for tracking and analyzing program data from Tier.Net - Health Connectivity Unit operational in 8 provinces to assess and support data integration	3 years
HISP	Information Systems	Support of critical HRH activities nationwide, including • Complete deployment of an interoperable health workforce registry • Establishment of a functional and up-to-date HRH data warehouse with trained end users • Establishment of a functional, standards-based information exchange interface between the HRH data warehouse and WebDHIS	Fully functional health workforce registry that is interoperable with HRIS and deployed in 2 provinces; Trained end users of an HRH data warehouse that is the single authoritative source of HRH data; All 9 provinces, 52 districts and 247 sub-districts transitioned to and reporting on webDHIS, Tier.net, and other web-based platforms.	3 years
Aurum Institute	Information Systems	Train NDOH staff through Knowledge Hub (HIV eLearning for NDOH staff) to increase knowledge and competency of OTLs	Trained HRH to serve as skilled and competent Outreach Team Leads	2 years
PwC	Information Systems	i) Maintain the Department of Health's Visibility and Analytics Network for ARV distribution. (Support upgrades for SVS, RxSolution and gCommerce systems). ii) Incorporate medical supplies (condoms etc.) supply chain visibility and analytics in provincial versions of the VAN	- All PEPFAR-supported facilities reporting stock availability at national surveillance center to monitor medicine availability - A central selection and contracting framework for medical supplies developed and incorporated into the VAN blue print	3 years
Pact, Inc.	Management and coordination	Support National Treasury with HIV/AIDS conditional grant and CHWs	- Written analysis of available ART costing data and assessment of need for additional budget allocations to sustain the ART Programme over the 2019 MTEF. - Written comments/analysis on draft HIV Financing Proposals, including reports from other NT Consultants. - Written Comments/Analysis on Global Fund SIB Proposals, Contracts and Implementation Plans.	2 years

Implementing Partner Name	Type of Investment	COP18 Activity	Expected Outcome	Expected Timeline for Achievement of Outcome
			- Evaluation Report on the CCMDD Programme.	
Project Last Mile	Supply chain systems	Scale up the private sector engagement model for the CCMDD program	- Increase number and improve distribution of CCMDD PuPs. - Three million patients receiving medicines through the centralized chronic medicine dispensing & distribution system.	2 years
PwC	Supply chain systems	i) Upgrade PMPU functionality to the NDoH endorsed blueprint in eight provinces. Ii) Plan, and facilitate phase out of TEE and Phase in of Dolutegravir for new and stable patients	- All provinces will have a functional Provincial Medicine Procurement Unit (PMPU) for the management of direct delivery of medicines established. - A central selection and contracting framework for medical supplies developed and incorporated into the VAN blue print.	3 years
Human Sciences Research Council	Survey and Surveillance	Assessments on South Africa's HIV Prevalence, Incidence, and Behavior	- 5th HIV Household Survey conducted, reported and data available for planning (PHIA-like survey). - Implementation of the 6th Survey for mid-term review of NSP (2017-2022). - Improved use of available information in planning	2 years
UNAIDS - Joint United Nations Programme on HIV/AIDS	Survey and Surveillance	Modelling, estimations and mapping of sub-national HIV burden	- District-level HIV estimates including on prevalence and burden (PLHIV). - Provincial and district-level staff trained on the generation, interpretation, and use of sub-national estimates. - Improved use for strategic planning and uses in DIP/MDIP processes to improve HIV response.	2 years
National Institute for Communicable Diseases	Survey and Surveillance	Enhancing HIV Case-based and ANC surveillance (Gauteng data repository establishment)	- Expansion of HIV patient monitoring through the establishment of a national data repository. - Improved data availability, accessibility, and use in Gauteng and for ANC surveillance. - Provincial instances of repository for sub-national use.	2 years

Implementing Partner Name	Type of Investment	COP18 Activity	Expected Outcome	Expected Timeline for Achievement of Outcome
Medical Research Council	Survey and Surveillance	Strengthening surveillance and implementing studies on linkage, retention, MTCT, and TB/HIV integration in South Africa	Established monitoring procedures for triangulating facility-based routine data systems with other data systems to locate barriers undermining linkage to and retention in HIV care.	2 years
University of California, San Francisco	Survey and Surveillance	Support for key populations including: modeling of key populations behaviors, evaluating a TGW intervention and social network strategy; an IBBS for MSM	Impact measurement of concentrated microepidemics on epidemic control; relevant programming offering prevention and treatment services to TGW; increased testing uptake by MSM.	2 years
UNICEF	Technical area guidelines and tools	Providing technical support to NDoH to integrate a package of care for adolescent/young pregnant and breastfeeding mothers	Reduction in MTCT rates of HIV among adolescent /young pregnant/breastfeeding women from 1% at 2 months to < 0.6% in 5 priority districts.	2 years
ITECH	Technical area guidelines and tools	Develop Regional Training Centers to guide performance strengthening of HIV care and treatment providers through HRID; integrate mental health within the primary health platform by training DSPs; Train counselors to identify and treat clients who are survivors of GBV	DSPs implementing patient-centered intervention; new system tracking HRH Rapid Assessment via HRID; PEPFAR-SA funded staff captured in system; Improved adherence, retention, and quality of life for PLHIV suffering from mental health conditions; Health care workforce equipped to appropriately treat survivors of GBV.	3 years
Health Systems Trust	Workforce development, pre-service training	Provide national level staffing support for key systems-based programs including integration of SYNCH with NHLS and Tier.net, secondment of staff to NDOH to support CCMDD activities, and training for health care managers and Outreach Team Leads.	All patients on CCMDD enrolled onto the electronic systems; adequate NDOH to support CCMDD activities; Master Trainers knowledgeable and competent to conduct supervisor training for 3,506 OTLs in 27 priority districts.	3 years
Stellenbosch University	Workforce development, pre-service training	Pre-Service: Integrate HIV content into national curricula at colleges of nursing Expand decentralized learning model to provide relevant HIV pre-service education to medical students at University of KwaZulu-Natal	HIV curriculum fully integrated into colleges of nursing, medical school.	2 years

Implementing Partner Name	Type of Investment	COP18 Activity	Expected Outcome	Expected Timeline for Achievement of Outcome
WHO	NA	Support for training on normative guidance to support index case testing, TB preventive therapy, switch to Dolutegravir based, and district health departments' use of real-time treatment cascade data.	TOTs capacitated to support training of district and facility teams in differentiated care beyond stable patients, phased implementation of DTG; training of District Teams to generate treatment cascades in real time for use for program and treatment monitoring.	2 years
To be Determined	NA	Provide continuous quality improvement activities focusing on safety and clinical training for the VMMC program	Use of standardized tools to implement continuous quality improvement activities and use data to implement changes. Completed quality assurance activities with NDOH to improve adherence to policy and guidelines; VMMC clinicians trained on dorsal slit technique; improvement in post-operative follow-up and AE rates.	2 years